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Military Chaplains' Review

Spring 1991

Medical Ethics

Professional Bulletin of the U.S. Army Chaplain Corps

This medium is approved for the official dissemination of material designed to keep individuals within the Army knowledgeable of current and emerging developments within their areas of expertise for the purpose of enhancing professional development.

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Military Chaplains' Review

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Planned for 1992

Health Care Professionals Short Course: Ethical Dilemmas in Military Health Care

4-8 May 1992, Radisson Hotel, San Antonio, Texas
Course Limit: 350

Ethical Dilemmas in Military Health Care is a health care professionals short course to be co-sponsored by The Surgeon General, U.S. Army, and the Army Chief of Chaplains.

This multidisciplinary course will include physicians, nurses, chaplain unit/hospital ministry teams, health care administrators, social workers, and other professionals of the Total Army health care provider team. Participants will examine bioethical principles, their application in clinical decision making, and the consequences of such decisions on patient care and health care provider team effectiveness. Members of other military services are also invited.

The course will focus on four key issues in Army health care: (1) abatement of life-sustaining treatment, (2) informed consent, (3) allocation of scare health care resources, and (4) ethical consultation. The implication of these issues in special circumstances such as trauma, mass casualty, and battlefield environments will also be discussed.

Course presentations from leading national military and civilian health care ethicists, dialogue with course faculty, and small group seminars will identify potential ethical crises points.

Tentative Civilian Faculty Includes:

Edmund D. Pellegrino, M.D.

Professor of Medicine and Medical Humanities, Senior Research Scholar, Kennedy Institute of Ethics, Georgetown University, Washington, D.C.

Sarah T. Fry, Ph.D., R.N.

Professor, School of Nursing, University of Maryland, Baltimore, MD.

Albert R. Jonsen, Ph.D.

Professor of Ethics in Medicine, Chairman, Medical History and Medical Ethics, University of Washington School of Medicine, Seattle, WA.

Kenneth V. Iserson, M.D.

Fellow in Bioethics, University of Chicago, Coauthored *Ethics in Emergency Medicine.*

Laurence J. O'Connell, Ph.D., S.T.D.

Director and C.E.O., The Park Ridge Center, Chicago, IL. President, Society for Bioethics Consultation.

POC: Chaplain (LTC) Dave DeDonato, (512) 221-6136/6935; AV 471-6136/6935.

Introduction to the Spring Issue

The articles in this issue are drawn primarily from the **Conference on Medical Ethics and the Health Care Provider Team on the Battlefield**, held in San Antonio in May, 1990. The issues raised by these presenters are critical, controversial, and absolutely essential to the knowledge of chaplains today in the arena of high-tech medicine which has the capability of prolonging life with extraordinary means. Those who are not informed about these issues, and have not grappled with the formidable implications will have a limited ministry, and may actually do a disservice to families committed to their care who will face these same issues.

Euthanasia is discussed frankly in several articles. No attempt is made to recommend it in any way; but historical examples are cited in **Dr. (MAJ) Steven Swann's** article which takes a penetrating and courageous look at situations on the battlefield.

Chaplain (LTC) Dave DeDonato has done an excellent job of putting together this issue. His expertise in the medical ethics field was invaluable, and credit goes to him for the wide and interesting variety of articles herein.

Don't miss the message of the short story by Air Force **Chaplain Melvin Brinkley**. Not only is it entertaining, it is penetrating!

Our next issue, Summer, 91, features articles and stories from chaplains involved in **Operation Desert Shield/Storm**. For the Fall issue, we will explore the possibilities and problems of Evangelism and Discipleship in the Military. Will you contribute to this subject? I need to hear how you all are doing it.

—Editor

Medical Ethics and the Soldier

Norris L. Einertson

Opening address delivered by Chaplain (MG) Norris L. Einertson. Army Chief of Chaplains, at the Medical Ethics and the Health Care Provider Team on the Battlefield Conference, San Antonio, Texas, 14 May 1990.

This is an historic workshop. It brings together officers and enlisted of the Reserve and Active Components, Combat Arms and Special Branches; members of the Total Army health care providers and members of the fighting teams of our Army. We have come together to discuss how we have acted and how we will act on future battlefields as we provide total health care for our soldiers on that battlefield. We need to do it now, before we get to the battlefield. Wasn't it the French General Foch who once said that an Army does well in combat only those things which have become second nature to it by virtue of its training? (If he didn't say it, he should have). There is of course good reason for this fact. The battlefield is always chaotic. There is little time for reflection. We must train so well that we will on the battlefield do the right thing instinctively.

We must analyze our actions on the battlefield to insure that they meet the highest moral standards. We must insure that our actions help to realize the "greatest good".

This is an ethics conference. We must draw together and focus our reflections on professional military and professional medical ethics in our inquiring this week.

I am delighted that the Surgeon General joined me in sponsoring this workshop. Chaplains and members of the medical community have always stood side by side during time of great crises. I want to especially thank the chaplains of Health Services Command and especially Chaplain Dave DeDonato for all their efforts in putting this workshop together.

When we discuss service to our soldiers who have been in combat, we are of course talking about serving soldiers who have been placed under great stress. Dr. Dave Marlowe, Chief of Psychiatric Research at Walter Reed

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Chaplain (MG) Norris L. Einertson, recently retired as Chief of Chaplains, U.S. Army, is ordained in the American Lutheran Church. He earned an S.T.M. from New York Theological Seminary, and is a graduate of the Army Command and General Staff College, the Industrial War College of the Armed Forces, and the Army War College. He is now pastor of Beaver Valley Lutheran Church in Valley Springs, SD.

Army Medical Center puts it this way: "The environment of combat for the contemporary American soldier is the most stressful, threatening and alien that human beings can be subject to. Each man committed to battle is the focus of two contending forces; those which would either physically or psychologically destroy him as a functional and capable combatant, and those which maintain. The power of the battlefield to break men can never be overstated."

No one who experiences the deadly brutality of war is ever quite the same again. Some return broken in mind or body. Others never return at all. Those who return with wholeness and health have explored regions of their souls and psyches which most have never explored, and may never explore. Few human beings experiences bring us such a deep awareness of our physical, emotional, and spiritual limits.

An article in *Preventive Psychiatry* states, "There is no such thing as getting used to combat. Each man 'up there' guesses that at any moment he may be killed, a fact, kept constantly before his mind by the sight of dead and mutilated buddies around him." The battlefield often has devastating effects upon those who fight. If conditions are severe enough, intense enough, and last long enough, it has the power to break the will of those the Army sends to fight.

The purpose of combat is to break down the soldiers' will. Both opposing forces want to create an "environment in which organized, coordinated, and effective combat" are impossible for their opponent. Carl von Clausewitz puts it this way: "If the enemy is to be coerced you must put him in a situation that is even more unpleasant than the sacrifice you call on him to make. The hardship of the situation must not, of course, be merely transient — at least not in appearance. Otherwise the enemy would not give in but would wait for things to improve. Any chance that might be brought about by continuing hostilities must, at least in theory, be of a kind that will bring the enemy still greater disadvantage."

Combat is one of life's most stressful experiences. Even short operations like the recent one in Panama produced very high stress, involving a compression of time which makes the battle seem to last forever. There is little time for sleep and little relief from contact with enemy. The modern battlefield is more intense and lethal than previous ones. Casualty rates are high. The fact that it is not a training exercise is driven home when the first mutilated bodies of our soldiers are sighted or reported.

What sustains soldiers during war is the personnel of their unit. Herbert Speigle made these observations on the relationship of group cohesion or morale and the sustainability of people in battles during the Tunisian Campaign:

> If abstract ideas - hate or a desire to kill - did not serve as strong motivating forces, then what did serve them at that critical time? It was love more than hate. Love manifested by 1) regard for their comrades who shared the same dangers, 2) respect for their platoon leader or company commander who lend them wisely and backed them with everything at their command, 3) concern for their reputations with their commanders and leaders, and 4) an urge to contribute to the success

> of their group and unit . . . these cohesive forces enabled them to identify themselves as part of their units . . . They seemed to be fighting for somebody rather than against somebody . . . They were fighting for themselves and their unit, and in that way for their country and their cause.

As we begin this week, we need to remember that all the discussion within our Army concerning unit cohesion in recent years is relevant for us. If the sense of being a unit is what sustains soldiers in battle, can we ignore this unit as we treat individual casualties? Can we ignore the love which binds soldiers together, nurtures their will, and builds their ability to fight?

I hope you will discuss what kinds of problems were created for soldiers when the surgeon was taken out of the unit. What has changed for the soldier and delivery of health care since that decision was made? I remember that prior to Vietnam and in Vietnam that soldiers treated the Battalion Surgeon as part of the unit. The Doc and the Chaplain shared insider status within the unit. We were part of the family. We were constantly reminded that casualties of were members of our family. Fellow soldiers wanted to know what happened to Pvt. Snuffy when he was evacuated from the unit. After the unit surgeon or I visited the Evac Hospital we brought good wishes from the unit to the patient, and served as a messenger to the unit concerning how Pvt. Snuffy was doing. When a member of the "family" was killed, the unit honored the dead with a memorial service. The surgeon and I were there to answer the medical and spiritual questions within the unit.

In view of what I have just said, we cannot afford to succumb to the American ideology of individualism when we treat casualties. The temptation to deal with casualties only as individuals is strong, but we cannot afford to design our systems in such a way that we ignore the wounded soldier's unit. S.L.A. Marshall eloquently pointed out that, "the greatest enemy of the rifleman (is) individual loneliness. Man is a gregarious animal. His greatest steadying force is the touch of his fellows". One of our most effective chaplain recruitment posters shows a chaplain running in formation with soldiers in a unit, with the caption on it, "When you're close, it's hard not to touch someone."

Do we have a system in place which helps soldiers to remain in touch with their unit once they become casualties? What is our responsibility to the unit as we treat and manage these casualties? Does our system enhance unit morale and the capacity of the unit to continue to fight? Or have we put in place a system which degrades a unit's capacity in combat?

We know that casualties affect unit morale. We also need to realize that how we manage casualties on the battlefield affects the leadership of the unit. How the unit commander treats the dead and wounded tells the soldiers a great deal about how concerned that leader is for all soldiers. How the commander treats the dead and wounded greatly affects how much personal risk they are willing to take to accomplish the units' mission. Small unit commanders build morale by concrete actions rather than abstract philosophical proclamations about "why we fight."

Morale is greatly affected by how well soldiers in battle are fed, resupplied, how well acts of gallantry are recognized, how mail and information get to the unit, and how fairly they are treated. Soldiers whose commanders

take care of their basic needs show that they are not alone. When commanders demonstrate sound technical ability and do these things, soldiers declare that leader good.

We need to remember that every time we treat or minister to a wounded soldier that we serve that small unit commander. His or her reputation and ability to lead are tied to our actions as care givers. We are agents of, and working on behalf of that commander as we take care of battle casualties. So we should ask, "Does the support we give to that wounded soldier help the commander to maintain high morale and cohesiveness in the unit?" "Have we freed the commander from concerns about casualties so that the unit can proceed with confidence to pursue the units mission?"

One investigator of unit performance during World War II made this interesting observation, "Group morale determines group morals. What is good for the outfit is right. What is bad for the outfit is wrong." I would be more comfortable if he had said, "Group morale sometimes affects group morals." Certainly the unit morale and the frustrations of soldiers at My Lai contributed to the breakdown of discipline and the atrocities there.

What we can take from this is to insure that what we do as chaplains and medical care givers for the wounded and his or her outfit is judged by the soldier to be right. We must include the soldier in our moral deliberations lest we fail to hear the voice of conscience. We must be able to articulate to soldiers that the manner in which we are caring for soldiers is good for the unit. When soldiers say, "Listen, that is not good", we need to understand that the statement is more than an empirical observation; it is a moral judgment.

Finally, we need to honor that soldier who is a casualty. Israeli research on combat stress clearly demonstrates that we do immoral things to soldiers when we do not trust them far forward on the battlefield. We need to return the lightly wounded soldier to duty in his unit as soon as possible. Not returning him to duty quickly indicates something to the wounded soldier concerning how his contribution to his unit is valued and how well he has recovered from his wounds.

Has our ability to evacuate quickly and to far distance treatment facilities caused us to remove some soldiers whom we should have returned to duty? Has the belief that it will be a short war caused us to evacuate soldiers instead of returning them to their units? Are we studying procedures used in Panama to determine whether they were right and good in a moral sense or are we only concerned that they seemed to work?

Soldiers in combat don't want to leave their fellow soldiers when they are sick or wounded. They are afraid to leave those they know to be their friends. They don't want to be transferred to a new outfit. They want to return to their outfit, to be with people in whom they have confidence. Soldiers draw confidence from the unit community. The unit is a source of courage to return to the battle.

Jacques Cousteau tells of an experience which he had while scuba diving in a cave which was filled with water. His air tank hit the top of the cave and it was severed from his mask. Fortunately his two observant

companions saw the air bubble emerging from his tank and rushed to his side to intermittently share their air with him until all could leave the cave. When it was all over, someone asked Mr. Cousteau the question, "What did you learn from that experience?" He replied, "I learned that when you're all alone, you're in bad company." The soldier knows that instinctively.

My purpose in this presentation has been to encourage you to do your ethical thinking in the context of the Army, to insure that your ethical thinking has been "grounded".

I am aware that the environment in which nearly every participant in this workshop works is very stressful. Add to that the possibility that we all could be caring for battlefield casualties very suddenly, and the environment can be seen as even more stressful. We must create the kind of ethical climate which helps to insure that the givers of care will not become the battle casualties of our own willful neglect of our own human needs. We have a moral obligation to think through the hard decisions we must make on the battlefield before we get there. Remember that an Army does well on the battlefield only those things which have become second nature to it because of training. Thinking through these hard decisions more will make us more capable of doing the right and the good.

When we travel on airplanes we always get a safety briefing. Those of us who travel a great deal can almost give it verbatim. At one point in the briefing the flight attendant says something like this: "In the unlikely event of the loss of cabin pressure, oxygen masks will drop from the compartment above your head. If you are traveling with a child, first place the mask on yourself, and then assist your child." There is of course good reason for that order of things. If you do not first protect yourself you will not be able to care for your child.

So my last word to you is a pastoral one. Take care of yourselves. Then remember to love your neighbor as yourself.

Keynote Address to the Conference on Medical Ethics and the Health Care Provider Team on the Battlefield

James G. Van Straten

Editor's Note: As an introduction, Dr. Van Straten read the following letter from Mr. Ron Ridenhour, addressed to the House Armed Services Committee of the US Congress. The letter, dated 29 March 1969 was instrumental in the subsequent investigation and discovery of the My Lai incident.

It was late in April 1968 that I first heard of "Pinkville" and what allegedly happened there. I received that first report with some skepticism, but in the following months I was to hear similar stories from such a wide variety of people that it became impossible for me to disbelieve that something rather dark and bloody did indeed occur sometime in March, 1968 in a village called "Pinkville" in the republic of Vietnam . . .

. . . I was awaiting orders for a transfer from HHC, 11th brigade to company "E", 51st Inf. (LRP), when I happened to run into PFC "Butch" Gruver, whom I had known in Hawaii. Gruver told me he had been assigned to "C" company, 1st of the 20th until April 1st, when he transferred to the unit that I was headed for. During the course of our conversation he told me the first of many reports I was to hear of "Pinkville."

"Charlie" Company, 1/20, had been assigned to Task Force Barker in late February, 1968 to help conduct "Search and Destroy" operations of the Batangan Peninsula. Gruver said that Charlie Company had sustained casualties primarily from mines and booby traps almost everyday from the first day they arrived on the Peninsula. One village area was particularly troublesome and seemed to be infested with booby traps and enemy soldiers. One morning in the latter part of March, Task Force Barker moved out from its

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Doctor James G. Van Straten, Ph.D. (COL, MS. USA Ret.) served 30 years on active duty in a number of assignments including senior medical advisor in Vietnam, Office of the Surgeon General, U.S. Army, and several tours on the staff and faculty of the Medical Field Service School, Academy of Health Sciences, U.S. Army. He earned his Ph.D. in Educational Administration from the University of Texas. Dr. Van Straten currently serves as Dean, Allied Sciences, at the University of Texas Health Science Center, San Antonio, Texas.

firebase headed for "Pinkville." Its mission: destroy the trouble spot and all of its inhabitants.

When "Butch" told me this I didn't quite believe that it was true; but he assured me that it was and went on the describe what had happened. The other two companies that made up the task force cordoned off the village so that "Charlie" Company could move through to destroy the structures and kill the inhabitants. Any villagers who ran from Charlie Company were stopped by the encircling companies. I asked "Butch" several times if all the people were killed. He said that he thought they were - men, women and children . . . Although he had not seen it, Gruver had been told by people he considered trustworthy that one of the company's officers, 2nd Lieutenant Calley had rounded up several groups of villagers (each group consisting of a minimum of 20 persons of both sexes and all ages). According to the story, Calley then machine-gunned each group. Gruver estimated that the population of the village had been 300 to 400 people and that very few, if any, escaped.

After hearing this account I couldn't quite accept it. Somehow I just couldn't believe that not only had so many young American men participated in such an act of barbarism, but that their officers had ordered it.

It was in the middle of November, 1968, just a few weeks before I was to return to the United States for separation from the Army that I talked to PFC Michael Bernhardt. Bernhardt had served his entire year in Vietnam in "Charlie" Company, 1/20, and he too was about to go home. "Bernie" substantiated the tales told by the other men I had talked to in vivid, bloody detail and added this. "Bernie" had absolutely refused to take part in the massacre of the villagers of "Pinkville" that morning and he thought that it was rather strange that the officers of the company had not made an issue of it. But that evening "Medina (Captain Ernest Medina) came up to me ("Bernie") and told me not to do anything stupid like write my congressman" about what had happened that day. Bernhardt assured Captain Medina that he had not such thing in mind. He had nine months left in Vietnam and felt that it was dangerous enough just fighting the acknowledged enemy.

Exactly what did, in fact, occur in the village of "Pinkville" in March, 1968, I do not know for certain, but I am convinced that it was something very black indeed. I remain irrevocably persuaded that if you and I do truly believe in the principles of justice and the equality of every man, however humble, before the law that forms the very backbone this country is founded on, then we must press forward a widespread and public investigation of this matter with all our combined efforts . . .

Sincerely,

/S/ Ron Ridenhour

Upon the arrival of that letter, from an infantry soldier who was not present when the My Lai massacre took place, the House Armed Services Committee took action which caused the formation of an investigatory body to look into the most serious ethical breakdown of the Vietnam War. In one sense, the My Lai incident does not fit into the context of this conference, for clearly it had nothing to do with medical ethics. In another sense, however,

an ethical breakdown of this magnitude probably bears some consideration, for medical personnel were involved. I have often wondered what role the organic medical support personnel played on that dark and bloody day of 1968. I have often wondered how many officers, perhaps medical department officers among them, were privy to the mission of Task Force Barker on that fateful day in March. Is it conceivable that a three company task force, perhaps 300 to 400 officers and men, could have carried out such a mission without some medical involvement? And after the massacre was over, is it conceivable that the dark and bloody secret could have been kept from all medical department personnel? Do you find it believable that not a single military doctor, or medical service corps evacuation helicopter pilot, or chaplain, or nurse would not have heard about the dark and bloody incident? Does it not seem strange, retrospectively, that the story did not break until a year after that dark and bloody day, and then by a soldier who was not even assigned to the unit at the time? From an ethical point of view, what are the responsibilities of health care professionals, members of the chaplaincy, other members of the officer corps, when they are informed of dark and bloody events such as the My Lai massacre? Silence, or insistence on investigation and full then disclosure of the facts? How many officers were aware of that dark and bloody incident? Read the voluminous report of investigation, now known as the Peers Report, and you'll get a general idea. Are ethical breakdowns typically handled the way that My Lai was handled? I honestly don't know, but in my heart and soul I want to believe that My Lai was an aberration, a distortion, something that could not happen again—ever.

Please do not misconstrue anything that I am to say this afternoon. I am very proud of the 30 years that I spent in the Army of the United States. I feel that our armed forces, as a general rule, operate in a highly ethical manner, that the law of land warfare is rigorously adhered to , that the Geneva conventions are followed, that we abide by not only the letter of the law but the spirit as well.

But I also know that there are breakdowns. Perhaps 99.9 percent of the actions of our medical forces are highly ethical, but it is that 1/10th of one percent that you must focus your attention on during this important conference. I applaud those who had the courage to undertake this effort, for as best I can determine this is the first ever large-scale conference to examine wartime medical ethics.

One more caveat before my remarks. My recollections focus much attention on Navy medical units and personnel. I want you to know that this is the case not because I think the Navy acted any less nor any more ethically than the Army or Air Force, but only because when I arrived in Da Nang, South Vietnam in July, 1966, there were no U.S. Army units in the First Corps Tactical Zone, and as an advisor I had relatively little contact with U.S. Air Force Medical Personnel.

I want to do two things during my brief remarks. One: to remind you of just how bad it can get, by focusing some historical attention on World War II and the grim events that occurred not in a bygone era but in my lifetime, and two: to present for your consideration five true glimpses, five vignettes, of that which I experienced in Vietnam, our most recent, large scale conflict.

First, an historical reminder, lest we forget how bad it was 50 years ago.*

Historical documents reveal very clearly that medical experimentation became institutionalized during World War II. Both parties to the conflict, the Allied and the Axis Powers, wanted cures for diseases that were ravishing their forces throughout the world. Dysentery was taking its toll, as was malaria in certain regions of the world, and venereal disease seemed to be everywhere.

In the United States, Franklin Roosevelt established the committee on medical research. The committee approached its work with a wartime mentality, and some of this mentality seemed to carry over after the war years. Disease was clearly seen as the enemy under this mentality: the researchers were the soldiers in the conflict; and all were convinced that victory could be theirs—given proper governmental funding and the will to see it through. I think it is safe to say that during the war, ethics received relatively minor consideration, and the notion of informed consent was given almost no weight.

In a 1987 article in the *New England Journal of Medicine* entitled "Ethics and Human Experimentation," Doctor David J. Rothman summarized the mood of World War II and the period immediately thereafter by writing, "The wartime environment also undercut the protection of human subjects, because of the power of the example of the draft. Every day thousands of men were compelled to risk death, however limited their understanding of the aims of the war. By extension, researchers doing laboratory work were also engaged in a military activity, and they did not feel the need to seek the permission of their subjects any more than the selective service or field commanders did of draftees. In a society mobilized for war, these arguments carried great weight. Some people were ordered to face bullets and storm a hill; others were told to take an injection and test a vaccine. In philosophical terms, wartime inevitability promoted utilitarian over absolutistic positions."

Only after the war did it become apparent that some researchers had gone far too far, especially researchers on the losing side of the conflict.

We cringe when we read that German physicians, sympathetic to the ideals of the Nazi Party, participated in early euthanasia programs in which the comatose and the insane were involuntarily killed.

It seems almost incomprehensible that near the mid-point of the present century, only 50 years ago, anopheles mosquitoes were flown in from swamps throughout the world to transmit malaria to subjects for study; that particles of glass and stone were injected into wounds to test the efficacy of new sulfa drugs; that Jewish and Russian inmates were stripped and chilled in icy waters and blizzards in order to conduct experiments on how best to revive frozen bodies. Nude Jewish women were used to thaw the nearly frozen inmates, and then the researchers had the additional callousness to report in graphic detail how revived subjects practiced sexual intercourse at body temperatures of 86 to 90 degrees Fahrenheit. The list of atrocities goes on

*The information on WW II atrocities and the Tuskegee Syphilis Study is closely paraphrased from chapter 9 of Gregory E. Pence's book, *Classic Cases in Medical Ethics*, McGraw-Hill Publishing Company, 1990.

and on. It stretches the mind to try and comprehend the mentality of physicians who would shoot captives to study gunshot wounds; who would implant hormones in an attempt to cure homosexuality; who would starve inmates to study the physiology of nutrition; who would surgically remove women's arms and legs to study regeneration.

Perhaps one name stands out above all others when studying the sordid record of medical experimentation during World War Two—the "Angel of Death" Dr. Joseph Mengele. The chronicle of his life during the Nazi reign of terror reads more like fiction than fact. But it is irrefutable fact.

We read that Mengele used to stand at a railhead greeting incoming trains whose boxcars were filled with Jewish people, men women and children. He visually examined them, looking especially for twins and other suitable subjects for his experiments. With a "flick of his wrist" he selected those he wanted.

Dr. Mengele desperately wanted to become a full professor of medicine at a German University after the war, and he keyed his plan to attain this goal to finding a way to overcome the effects of genetics. He sought identical twins who served as natural controls for any environmental differences between them. He wanted to find ways to guarantee, blond hair, blue eyes, and healthy bodies that were free of all genetic disease.

He made female twins have sexual intercourse with male twins to see if twin children would be produced. At one point in his career, he isolated six children and experimented by injecting dye into their bodies to see if he could make their eyes turn blue. When finished, he cut out the twelve eyes and hung them on his laboratory wall, along with other human organs that some allege were removed from bodies while still alive.

In other so-called sterility experiments he subjected a group of Polish nuns to high doses of radiation, burning all of the nuns severely.

Mengele was noted as being cool, impersonal and detached. Occasionally, however, when someone tried to subvert his plans, his temper flared. Eyewitnesses record that on one occasion 300 children, quite by accident, escaped death in the gas chambers and fled to a nearby field. Mengele, angered, ordered a gasoline fire set in a large pit and then watched as the children were thrown into it. Screaming for their lives, some children were able to claw their way over dead bodies to the top, where Dr. Mengele and SS soldiers kicked them back in.

Also in the name of medical research, Dr. Mengele one day watched a hunchbacked man and his young son get out of a boxcar. He ordered both killed immediately, their bodies boiled, their flesh stripped, and the skeletons dipped in gasoline for preservation for his anthropological studies of body types.

Yes, we cringe and we are appalled. During the same war, Japanese physicians secretly killed over 3000 Chinese prisoners in medical research, especially at unit 731 in Harbin. The prisoners were injected with dozens of diseases, among them anthrax, syphilis, plague and cholera, all to study the natural course of the disease. On one occasion, 700 Chinese died in a plague study; on another occasion a man's body was filled with the blood from a horse.

And at the same time in the United States, not in a military setting, the infamous Tuskegee syphilis study that started in 1932, was still in operation until 1944. It was racist, dehumanizing, and a sordid chapter in American medical experimentation.

Have we had wartime medical practices subsequent to World War II that were questionable from an ethics point of view? Have they been of the magnitude of World War II? Not in my estimation. Nevertheless I must tell you that I frequently had cause for ethical concern while serving in Vietnam, our last major conflict.

What was the nature of my concern, and are there any lessons to be gleaned from that war which might prove helpful in studying combat bioethical decision making processes? Perhaps if I present four or five short vignettes of things I actually experienced in Vietnam you'll get a feel for my concerns.

I served not with U.S. forces in Vietnam, but as a medical advisor to the Army of the Republic of South Vietnam in the First Corps Tactical Zone, roughly the area from Quang Ngai City in the south to the demilitarized zone in the north.

When I arrived in Vietnam in July of 1966, there were no U.S. Army Units in I Corps. There were U.S. Navy Units, lots of Marines, and many Air Force Units. Army units started moving into I Corps in late 1966, when Task Force Oregon was moved into southern I Corps. I had the unique advantage of seeing on the ground, in combat, the U.S. Navy, U.S. Marines, U.S. Air Force and eventually the U.S. Army, while working directly with medical units of the Army and Air Force of the Republic of South Vietnam. What did I see that gave me cause for bioethical concern?

Vignette #1: In September 1966, a joint operation was planned using U.S. Marines and elements of the First Vietnamese Infantry Division, headquartered in the Old Imperial City of Hue. My Vietnamese counterpart, the I Corps surgeon, was instructed that heavy Vietnamese casualties were to be expected, and that the patient census of the Vietnamese Station Hospital at Hue should be reduced significantly in preparation for the wounded expected to result from the impending battle above Hue. Highway 1, the only ground artery from Hue to Da Nang was cut and impassable. Air Evacuation to Da Nang's General Hospital was the only feasible alternative. Vietnamese air evacuation capability was extremely limited. After many calls and very close coordination, the U.S. Air Force agreed to provide aircraft to evacuate approximately 240 patients from Hue to Da Nang.

To accomplish this evacuation, all 240 patients had to be moved by ground transportation from the station hospital at Hue to the Hue-Phu-Bai Airport, a distance perhaps 10 miles to the south.

We thought the coordination was perfect. No patient was to be loaded into the ground transportation that we had lined up until the aircraft coming from Saigon's Tan Son Nhut Airport were in the air. The call came. The planes were in the air.

We loaded the patients. The heat was frightening, perhaps 105 degrees. The vehicles were dispatched in a convoy. Armored vehicles accompaniedthe convoy for protection.

The convoy arrived at the Hue Phu-Bai Airport. There were no transport aircraft on the runway. We parked the vehicles in the shade as best we could and opened all doors to provide some ventilation for the patients.

We waited. No aircraft arrived. Thirty minutes passed. Heat radiated off the runway. We tried to call Saigon from the operations tower and couldn't get through. One hour passed. Vietnamese medics circulated among the patients and gave water, checking on their condition. The situation was deteriorating. The tower was trying to reach Saigon to get a status report on aircraft. Nothing. Vietnamese doctors became more and more concerned and nervous. One patient expired. The tower got through to Saigon, but could not get any answers. Where were the promised aircraft? Another patient died, then another. The situation was getting desperate. The tower contacted Saigon, but Saigon was evasive. Another patient expired.

Then came the truth. U.S. officials doubted that the Vietnamese could get their 240 patients from Hue to Phu-Bai on time, and therefore committed the aircraft to haul supplies from Saigon to Nha Trang, and after offloading the cargo in NHA Trang, to go on to Phu-Bai for the patients. Aircraft finally arrive, almost two hours late. Seven Vietnamese patients died, and many more were in very bad shape because of the heat. How many more died as a result of this exposure I do not know. The patient tracking system was not sophisticated enough to provide me the answer to that question which I angrily asked.

Is there an ethical dimension to this situation? In my mind yes, But I let you be the judge. All I can tell you is that despite my angry protests, U.S. officials treated the incident rather cavalierly and lightly. Would we have reacted in a similar manner had the casualties being evacuated been American soldiers or marines? I don't think so. Are the ethics of the situation somehow different because the patients were those of an ally instead of our own? I honestly don't know.

All I know for certain is that at least seven young men died during a medical evacuation operation that my Vietnamese counterpart and I thought had been perfectly coordinated.

Vignette #2: Early in 1967, South Vietnamese and American forces located near the DMZ were taking quite a number of casualties as a result of fire from a high trajectory weapon not too unlike a mortar which came to be known as a rocket. Analysis indicated that the fire had to be coming from the so-called demilitarized zone. Further analysis pinpointed firing locations, all near Vietnamese villages, making it impossible to neutralize the incoming fire without putting the non-combatant population at great risk.

A decision was ultimately made that the people in several of the small villages, both within the DMZ and near the DMZ, had to be relocated to refugee centers in safer locations within Quang Tri province of South Vietnam.

The first move of refugees was carefully planned, with medical input as appropriate. The move started. Entire families, with their meager possessions, were loaded aboard trucks for the move, while other families awaited their turn. Animals owned by the families were tethered to the trucks and

followed along behind. Apprehension among the refugees, as you might imagine, was frighteningly high. There was much wailing and resistance at first, but then stoic resignation as this slow convoy, with animals following, wound its way from the DMZ to the resettlement area. It took about two to two and a half days for each convoy to make the journey. Food and drink were provided along the way. However, one problem arose that was unexpected, and it proved to be a serious problem.

Probably as a direct result of the apprehension, many mothers with new born babies stopped lactating. Medical authorities, both Vietnamese and U.S. became aware of the problem when several new born babies died, probably of dehydration. No non-human milk nor bottles were available, and new mothers seemingly didn't know how to cope. Some tried wet nurses, but they were difficult to find in the confusion of the convoy, and, besides that, many of them had likewise stopped lactating.

I recall a conversation between medical authorities of South Vietnam and the United States Navy, who were in support of the Marines executing the move. It was decided that although more moves of people from other villages on subsequent days were planned, the problem was not severe enough to bring to the attention of line unit commanders in charge of the move. The rationale seemed to be that little could be done, since baby bottles and milk other than mother's milk was foreign to the culture of the Vietnamese. Result: I am personally aware of 17 babies dying during these forced relocations. Was it an ethical decision to let the moves proceed without properly addressing the problem? I honestly don't know, but I do know that babies died. I also know that in later moves, that were executed subsequent to the first series of moves, baby formula and bottles were available and were used.

Vignette #3: Sometime in the spring of 1967, A three person delegation from the International Red Cross visited the barbed wire enclosed P.O.W. Camp which was located near Marble Mountain, on the outskirts of Da Nang. I was asked to accompany the visitors. There was a Swiss physician heading the international team. As I recall, South Vietnamese prison officials stated there were about 850 Viet Cong, North Vietnamese regulars and political prisoners in the prison. Both U.S. Forces and South Vietnamese Forces were allowed to incarcerate captives in the camp, although the camp was officially run by the Army of the republic of South Vietnam.

The camp was a mess. Sanitation was unbelievably bad. Food was atrocious, and total medical support consisted of one full-time South Vietnamese enlisted medic assisted by two elderly women with marginal medical knowledge and skill. In addition, a South Vietnamese Army physician from Doi Tan General Hospital was supposed to visit the prison once a week.

The Swiss doctor was appalled, and he asked to speak to both South Vietnamese and U.S. Military medical authorities. The first visit was to South Vietnamese Military medical authorities at Doi Tan General Hospital. The South Vietnamese commander and staff smiled politely but refused to commit anymore scarce medical resources to the effort, and, in fact, Doi Tan General Hospital was woefully understaffed.

The next visit was to the commander of the U.S. Navy Hospital in Da Nang, and to his credit, the he agreed to put out a notice asking for volun-

teers, but he absolutely refused to order any members of his staff to commit their time and talents to the P.O.W. camp. How many volunteers offered help? To the best of my knowledge one nurse, one physician, an ophthalmologist, who happened to have been born in the Philippines, and two Navy corpsmen. Every one else refused to help, many making statements unworthy of repetition. Did they have time available to commit? Emphatically, yes. Was their behavior ethical? You be the judge. Some would say yes; others will say no.

Vignette #4: One Sunday afternoon, shortly before I was due to leave Vietnam in the summer of 1967, many of the on-call physicians, nurses and corpsmen at the U.S. hospital in Da Nang were engaged in a volleyball tournament in a sandy area adjacent to the hospital. Most were drinking copious quantities of beer. The mood was raucous.

All of a sudden an announcement came over the loud-speaker system to the effect that a Marine battalion had taken heavy casualties in an adjacent province, and that evacuation aircraft, loaded with wounded, were expected at the hospital helipad shortly.

Did the volleyball game stop? Not for one minute. The aircraft stared landing and disgorging the wounded into the triage and emergency treatment rooms before the game stopped. Did Marines die in the hospital that day? I know for certain that two did. Would they have died had the hospital staff been better prepared to receive them? No one will ever know.

Did those who continued to play volleyball and drink beer, after having been notified that casualties were on the way, act in an ethical manner? You be the judge. Did the acting hospital commander (the commander was on R&R) who knew of the continuance of the game and the beer drinking, and elected to do nothing about it, act responsibly and ethically? Again, I don't know, but I do know that that day has stuck firmly in my memory as one I don't wish to repeat. Ever.

Vignette #5: Heavy casualties came into the U.S. Naval Support Hospital in Da Nang. A. U.S. marine battalion and an ARVN battalion were caught in the open in a driving monsoon rain, at night, by a North Vietnamese battalion of regulars, which poured mortars on them producing heavy casualties.

I noted as they off-loaded the helicopters that one of the wounded was a South Vietnamese soldier. This was not too unusual, as occasionally in the heat of battle casualties got mixed and put into incorrect evacuation channels. In fact, quite frequently U.S. helicopters would off-load casualties at the U.S. Navy Support Hospital in Da Nang, and then fly the short distance to Dio Tan General Hospital and off-load South Vietnamese casualties.

In this instance, however, since the helicopters had to return immediately to the scene of the battle for more wounded, and since there was only one wounded South Vietnamese soldier, he was off-loaded and taken into the triage and emergency treatment area along with the U.S. marines casualties.

I watched him, probably because I was the Corps level medical advisor to the Vietnamese. He was carefully placed apart from the casualty flow. U.S. Marine casualties were quickly surveyed, I.V.s were started, some were taken to surgery, cleaning and debridement of wounds began, but the South

Vietnamese soldier remained unattended. I looked at him. He looked as if he were going into shock. He was bleeding from an extremity wound and what appeared to be a rather superficial head wound. His color was worsening.

It appeared to me as if most U.S. wounded were under control. Still, nobody approached the South Vietnamese soldier. Somewhat in desperation, I made an issue of it. I was forcefully told that South Vietnamese medical authorities had been informed of the wounded soldier, and that it was their responsibility to come get him and take him to Doi Tan Hospital.

I verified that the call had been made. The Vietnamese stated they would respond as soon as transportation was available. Another 30-minutes went by. Still no response. The shock, in my opinion, was becoming much more pronounced. I again approached a U.S. official, and was bluntly told that he, the South Vietnamese soldier, would be looked at *only* after every U.S. serviceman had been cleared from the emergency treatment room, and not before.

Another fifteen minutes passed, and just as I was about to go find the commander to make an official issue of it, a South Vietnamese ambulance arrived and evacuated the soldier to Doi Tan General Hospital. Without question the soldier was in bad shape by this time. Did he live or die? I honestly can't say, but the situation bothered me greatly. The next day I made an official complaint over the happening. Eventually I got the U.S. hospital commander, and he told me that there was a "gentlemen's agreement" between himself and his Vietnamese counterpart to the effect that when U.S. casualties came into Doi Tan Hospital they would not be treated. A phone call was to be made to the U.S. hospital and the wounded soldiers were to be picked up by U.S. ground ambulance or helicopter and transported to the U.S. hospital. Clearly, and perhaps with justification, U.S. authorities did not want their wounded treated in South Vietnamese hospitals and they therefore entered into the "gentlemen's agreement" mentioned above. Was this an ethical action? U.S. authorities were very much aware of the scarcity and unreliability of South Vietnamese evacuation vehicles when they proposed this "gentlemen's agreement." Again, you be the judge, but I must tell you that I witnessed similar events quite frequently, and my reaction was always the same—I didn't like it.

And so it went in South Vietnam. Most medical activities seemed to be highly ethical, but some were very suspect and troublesome, especially as they related to medical activity with our allies, the South Vietnamese.

In closing, let me state emphatically that I am not an ethicist, but there were many times in Vietnam that I faced ethical questions unlike any that I faced before or am likely to face in the future. I know the pain of war; I've watched death on the battlefield. In one minute a breathing, thinking person, capable of love and hate can be changed by the crack of a machine gun into a body from which life flows out. The hands which were once so expressive of the life within, start to get rigid, the lips quiver, and death comes.

Somehow it seems to me that the suddenness of death during war, the frequency of death during war, the lack of time available for ethical decision

making in war, all conspire to compound the problems that we are dealing with this week.

Ethics has been defined as the science of morality of human acts. It is a science because it is a body of ordered truths, the order and the truth being supplied by rational analysis of evident facts. The English word "ethics" comes from the Greek word ethos. Ethics is also called moral philosophy, from the Latin "mores," which, like the Greek term signifies customs or morals.

Morality is the goodness of the badness, the rightness or the wrongness, of human acts. It is right human conduct to choose the good, and wrong human conduct to choose the evil.

No matter what activity man or woman may engage in, that activity must be regulated by the moral law in every detail of its exercise. Every human action of man or woman should be subject to the law of reason, and every concrete human action is a moral action. Man or woman by nature cannot be amoral. Every science and every art must have its ethical implications and is therefore subject to ethical standards.

And with my experiences in Vietnam and the horrors of WW II as background, I wish you the very best as you engage in dialogue during this important conference. Major General Marc Cisneros, the ground commander of U.S. forces during the recent invasion of Panama, gave an address at the commissioning ceremony for the ROTC cadets at St. Mary's University on Saturday of last week. In his remarks he cautioned the newly commissioned officers "to never forget that war is the ultimate stupidity, but that evil men in positions of power must always be confronted." He stated emphatically, "You'll find evil people out there. You'll find evil people in your own platoon." And I would add, you'll also find a few unethical people out there, and that's why a conference such as this is so vitally important.

From Plato to NATO; the Ethics of Warfare; Reflections on the Just War Theory

John Brinsfield

The ethics of warfare are professional military ethics rooted in history and reflected in such modern documents as the United Nations Charter, the Geneva Conventions, and FM 27-10, *The Law of Land Warfare*. Members of the health care team on the battlefield, physicians, nurses, medics, chaplains, and chaplain assistants among them, have a strong interest in the ethics of warfare as health care providers and as military professionals. They have argued that without strict limitations on the conduct of war, to include the immunity of field hospitals from direct attack, military operations quickly become contests of attrition with unacceptable casualty rates among both military and civilian personnel.

The history of the ethics of warfare includes many theories including those of the Holy War, the Just War, the Crusade, the Limited War, and the Total War. The theory which has been most influential in Western Civilization, and which seems most compatible with the emphasis in medical ethics of avoiding unnecessary suffering, is that of the Just War. A brief survey of Just War terminology, origins, interpretations and issues may serve to highlight the relationship between military and medical ethics for those interested and involved in the health care professions.

Terms and Definitions

"Morals" has to do with rules or principles of behavior whereas "ethics" deals with the justification or rationalization for those rules. The terms "moral" or "immoral" should address the question, "Is this action right?" The term "ethics," as a branch of moral philosophy, should answer the question, "Why is it right?" Thus one would be able to discuss the *morality* of a given action within the context of utilitarian, theocentric or even situational *ethics*.

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The term metaethics is sometimes used to indicate an approach to a further question, "What gives me the right or authority to select one ethical position over another?" Typical answers to this question have ranged from appeals to God to personal inclination. The Christian bishops at the Council of Clairmont, when authorizing the First Crusade in 1095, proclaimed, "God wills it!" whereas Professor Alfred Ayer in the twentieth century believed that "ethical judgements are mere expressions of feeling."[1] Professor George Edward Moore pointed out, however, that if moral or ethical statements were simply expressions of personal feelings, it would be impossible to argue about questions of relative value.[2]

At the very least one might suggest that a *moral* as opposed to a *practical* question exists when a premeditated choice between at least two alternative actions is required *which questions in some sense the standards and values of society* with respect to right and wrong conduct. Such a choice must be voluntary and not coerced, for as Aristotle noted in *The Nicomachean Ethics*, "it is only when a man feels or acts willingly that he deserves praise or blame; feelings or actions that are unwilling are pardoned or even pitied."[3]

To the extent that all military actions have a moral component, and are usually justified by an ethical statement, these definitions may stimulate analysis and discussion. Indeed the Just War theory itself has been seen by some scholars as a moral code establishing not only which wars are just or unjust but also establishing a theory of "war guilt."[4] For others the Just War theory has been seen as an ethic, justifying moral participation in the organized killing and chaos peculiar to war. To fully evaluate any historical period, then, the historian of the ethics of warfare must not only be able to evaluate the components in any given theory of ethics, but also the function of the theory as a whole.

Origins of the Just War Theory in The Greco-Roman Period: Justice as Rational Statecraft

The problem for the Greeks involved in the Peloponnesian Wars of the fifth century B.C. was how to prevent the total destruction of Greek City states and their associated colonies while suppressing localized rebellion and winning their own civil wars.[5] Some policies dictated complete devastation and mas-

[1]A.J. Ayer, *Language, Truth, and Logic* as cited in William Jones, et. al., *Approaches to Ethics* (New York: McGraw Hill, 1977), pp. 546-547.

[2]George E. Moore, "The Nature of Moral Philosophy" as cited in William Jones, et. al., *Op. cit.*, p. 547.

[3]As cited in Philip Wheelwright (tr.), *Aristotle* (New York: The Odyssey Press, 1951), p. 200.

[4]See Roland H. Bainton, *Christian Attitudes Toward War and Peace* (Nashville: Abingdon Press, 1960), p. 95, and F.H. Russell, *The Just War in the Middle Ages* (London: Cambridge University Press, 1975), p. 20.

[5]In April of 404 B.C. Thebes and Corinth demanded the total destruction of Athens. The Athenian position enunciated in the Melian Dialogue of 417 B.C., ". . . that in human reckoning the question of justice only enters where there is equal power to enforce it and that the powerful exact what they can and the weak grant what they must," was thus proposed against them. See Benjamin Jowett (tr.), *Thucydides: The Peloponnesian Wars* (New York: Washington Square Press, 1963), pp. 181, 335.

sacre of whole populations, but left the problem of how to rebuild peaceful cities from rubble. This problem was highlighted by the speech of Diodotus of Athens in his debate with Cleon over the fate of the city of Mytilene on Lesbos in 427 B.C.:

> The siege will be costly because there is no capitulation; and if we capture the place, the city we have acquired will be in ruins; and we shall in future lose the revenue from it; but it is our revenue thaf makes us strong against our enemies. We should not then act as strict judges of offenders to our own hurt, but rather have an eye to the future and impose moderate punishment, and then we shall have cities financially strong at our disposal.[6]

Thucydides noted that Diodotus concluded his speech with the observation that "Wise deliberation is more potent against an adversary than attacks made in force and folly."[7] Diodotus' motion prevailed after a close vote, and the city was spared.

Almost sixty years after the debate over Mytilene, the philosopher Plato wrote *The Republic* in Athens as an answer to the question, "What does Justice mean?" and "How can Justice be realized in human society.?"[8]

In his commentary on "Usages of War" he noted:

> Accordingly, the Greeks being their own people, a quarrel with them will not be called a war. It will only be civil strife, which they will carry on as men who will some day be reconciled. So they will not behave like a foreign enemy seeking to enslave or destroy, but will try to bring their adversaries to reason by well-meant correction. As Greeks they will not devastate the soil of Greece or burn the homesteads; nor will they allow that all the habitants of any state, men, women, and children, are their enemies, but only the few who are responsible for the quarrel. The greater number are friends, whose land and houses, on all these accounts, they will not consent to lay waste and destroy. They will pursue the quarrel only until the guilty are compelled by the innocent sufferers to give satisfaction. For my part, I agree that our citizens should treat their adversaries in that way, and deal with foreigners as Greeks now deal with one another.[9]

For these views, which include the principles of discrimination and, to some extent, proportionality of punishment, Plato has been recognized as one of the "earliest writers to stand for the rule of international law."[10]

Yet in spite of the fact that the Greeks, and more specifically Plato's disciple Aristotle, coined the term "the just war," they did not fully describe the theory in a systematic way.[11] The twin components of "jus in bello" or just conduct and "jus ad bellum" or *just cause* were contributions of the Roman juridical mind.

The Roman concept of justice was the legal codification of a Greek philosophical notion. Harmony in the state could be achieved by giving each

[6]*Ibid.*, p. 106.

[7]*Ibid.*, p. 107.

[8]Francis M. Cornford (tr.), *The Republic of Plato* (London: Oxford University Press, 1962), p. 1.

[9]*Ibid.*, p. 174.

[10]*Ibid.*, p. 168.

[11]Aristotle thought wars by which the Greeks enslaved barbarians who were by definition less worthy and virtuous than Hellenes were "naturally" just. See Aristotle's *Politics*, I, 7-9 as cited in F.H. Russell, *The Just War in the Middle Ages* (London: Cambridge University Press, 1975), p. 4.

man his due reward or punishment according to his deeds. Thus the famous jurist, and later Consul, Marcos Tullius Cicero wrote in the first century B.C.:

> It is the first requirement of justice that a man shall not injure another unless provoked by wrong. In administering justice, care must be taken that the punishment be not greater than the crime and that some be not punished for the same offenses for which others are not even indicted.[12]

Cicero believed, as had Socrates before him, that justice was a universal virtue; for as Cicero noted, "Those who say that consideration must be had for the rights of citizens, but would deny these rights to foreigners, are destroying the universal brotherhood of the human race; if this be destroyed, kindness, generosity, goodness, and justice are at the same time utterly destroyed."[13]

Cicero was not the only source of information about Roman values in the latter days of the Republic, but his books *De Officiis*, *De Republica*, and *De Legibus* became standard authorities on Roman law for almost four hundred years and were quoted frequently by St. Augustine of Hippo who had read them originally as a student of rhetoric in Rome.

Cicero's codification of the Just War theory included both just cause and just conduct. He believed that war should be undertaken only after an injury or an insult to the honor of a state had been sustained and "only in case we may not avail ourselves of discussion."[14] No war was considered to be just unless waged as a last resort after demands for justice had been made, warning of action given, and a formal declaration of war proclaimed.

Examples of just causes included defending the state from external attack and recovering lost goods. Included in the category of goods was anything for which satisfaction was demanded, whether real property or incorporeal rights.[15] Moreover, wars might be fought to avenge injuries done to allies. Cicero noted a bit ironically that by "defending" her allies Rome had gained dominion over the whole world.[16] The idea of punishing one's enemies for attacks on one's friends thus became a part of the Roman code of war.

The ultimate objective of a just war was to establish peace with justice. Cicero specified that "the only excuse for going to war is that we may live in peace unharmed."[17] If satisfaction for injury to the Roman state or to one of its allies was not made within thirty-three days of a notification of grievance, the Senate could authorize the priests of Rome to issue a formal declaration of war.[18] Even so, negotiations for peace could be proposed by either party and at any time.

[12]Cicero, *De Officiis* as cited in Annabel Horn and John F. Gummere, *Using Latin* (Atlanta: Scott, Foresman and Company, 1954), p. 230.

[13]*Ibid.*

[14]Walter Miller (tr.) *Cicero: De Officiis* (Cambridge, Mass.: Harvard University Press, 1961), p. 37.

[15]A. Nussbaum, "Just War - A Legal Concept?" *Michigan Law Review* XLII (1943), 454 as cited in F.H. Russell, *The Just War in the Middle Ages*, p. 5.

[16]F.H. Russell, *Op cit.*, p. 5.

[17]Walter Miller, *Op cit.*, p. 39.

[18]F.H. Russell, *Op cit.*, p. 6.

The conduct of war should be in keeping with the long-term objectives of peace and justice. Thus Cicero warned his countrymen not to be too ruthless:

> As to destroying and plundering cities, let me say that great care should be taken that nothing be done in reckless cruelty or wantonness. It is the great man's duty to single out the guilty for punishment, to spare the many, and in every turn of fortune to hold to a true and honorable course.[19]

Cicero assumed within this context that the combatant parties involved in the contest were clearly able to be identified. Nevertheless, he warned that "the man who is not legally a soldier has no right to be fighting the foe."[20]

If one were to fault Rome's ethic of war it might be in the legal consequences of her victories and in the subjectivity involved in determining "war guilty," for it was assumed that only one party could be just in any contest.[21] The longer and more costly the wars became, the more likely it was that Rome would simply assume sovereignty over captured territory and enslave the population. Both booty and territory became the property of the government after a tithe was offered to the gods and the soldiers were properly paid.

Nevertheless, by the fourth century A.D., the Roman Just War theory contained almost all of the major components to which modern ethicists refer. The components for a war to be just were that the war must have just cause, just conduct, proper authority and the intent to establish peace and justice. The just war was undertaken only as a last resort. Cicero himself also held to the principles of discriminating between the innocent and the guilty and of making sure that the punishment was proportional to the crime. Only in rebellions, in guerrilla warfare and in wars with totally uncivilized barbarians were these rules ignored with impunity. Even then, as in the case of the wars with the rebellious Jews (68-70 AD), a few rabbinic scholars were allowed to continue to work and teach within Judea itself while the battles were being fought.[22]

The origins of the Just War theory in the Greco-Roman world, then, were not primarily religious in origin. They were rather judicial and philosophically rational principles designed to encourage discussion between adversaries and to limit warfare among civilized peoples. These principles were necessary in order to administer an Empire composed of many subject populations, and they presupposed a degree of national consolidation, a monarchial government, and a system of military defense.[23] With the triumph of Christianity in the late fourth century A.D. a new cast was given to the theory by St. Ambrose of Milan and St Augustine of Hippo, which would inaugurate for the Church a major role in international affairs.

[19]Walter Miller, *Op cit.*, p. 37.

[20]*Ibid.*, p. 39.

[21]F.H. Russell, *Op cit.*, p. 7.

[22]Rabbi Ben-Zakkai was allowed to move his school out of Jerusalem to Jamnia in 69 A.D. by Vespasian. The Jews were not expelled from Judea until after the Bar Kochba revolt in 135 A.D. See Max Dimont, *Jews, God and History* (New York: Simon and Schuster, 1964), p. 104.

[23]R.H. Bainton, *Op. cit.*, p. 45.

Christian Idealist Interpretations: The Early Church to St. Augustine

The Christian documents relating to the "justum bellum" prior to the fourth century are fragmentary and incidental. *The Reproaches* of Celsus (A.D. 170-180) indicate that it was not the policy of Christians to serve in the Army.[24] Tertullian's *De Corona Militis* (A.D. 211) was written in defense of a Christian who was imprisoned for refusing to wear the garb of a soldier.[25] Dr. Roland Bainton cites a list of 176 Latin inscriptions from the last half of the third century which indicates that Christian units were serving under Marcus Aurelius,[26] but Eusebius Pamphilii in his *History of the Church from Christ to Constantine* notes that Christians who served in the Army under Galerius were subject to persecution.[27] Probably the degree to which Christians participated in military forces in the first three centuries varied from place to place. Those who were converted prior to the time for enlistment may have resisted induction much more than those who were in the ranks already. At any rate, Professor Joan Tooke's statement that "the early Church did not encourage an elaborate theology of war" does not seem to be seriously challenged.[28] In fact, "there is no evidence whatever of Christians in the army" from the end of the New Testament period until A.D. 170.[29]

The Christian interest in the Just War theory arose primarily after the victory of Constantine, although Origen and Clement of Alexandria had mentioned the just war in connection with exegetical works on Deuteronomy 20 earlier.[30] The motivation for a Christian doctrine of war seems to have been centered in the defense of the Christian state. There is no mention of aggressive wars in St. Athanasius's (c. 373) works, although he noted that while "murder is not permitted, to kill one's adversary in war is both lawful and praiseworthy."[31] This theory of the defensive war as both lawful and laudatory depended upon the establishment of Christian society under Roman protection.

For St. Athanasius, St. Ambrose, and St. Augustine the just war was primarily a war of defense against barbarian invasions. Thus, St. Ambrose (c. 375), who was a Roman prefect before he became a bishop, declared in his *De Officiis Ministrorum* that the "courage which protects the homeland against barbarians in war is full of righteousness."[32] Augustine, too, seems to regard the barbarian invasion as a catalyst for his doctrine of war.[33] Professor

[24]Roland H. Bainton, *Christian Attitudes Toward War and Peace* (New York: Abingdon Press, 1960), p. 68.

[25]Joan D. Tooke, *The Just War in Aquinas and Grotius* (London: S.P.C.K., 1965), p. 3.

[26]Bainton, p. 69.

[27]Eusebius Pamphilii, *History of the Church* (Baltimore: Penguin Books, 1965), p. 355.

[28]Tooke, p. 1.

[29]Bainton, p. 67.

[30]*Ibid.*, p. 84.

[31]As quoted in Ralph L. Moellering, *Modern War and the American Churches* (New York: The American Press, 1956), p. 51.

[32]*Ibid.*

[33]In Henry Paolucci (ed.), *The Political Writings of St. Augustine* (Chicago: Henry Regnery Co., 1962), p. 286.

Van Der Meer notes that Augustine, in his role as Bishop of Hippo, realized that to preserve order the heretics should be forced into the Church and the generals encouraged to subjugate the barbarian raiders in spite of the fact that Augustine himself was a personal pacifist.[34]

Against the background of the fall of Rome and the barbarian "invasion" of Africa, Augustine formulated the full Christian Just War theory that lasted through the Middle Ages.[35] His pagan source was Cicero; his Christian source outside of Scripture was Ambrose. Augustine's own works which discuss war are scattered throughout his lifetime. They include his commentary on Joshua, his *City of God,* his *Confessions*, and his letters.

St. Augustine's theory of the Just War, then, included the components that Cicero had stressed but with the addition of five key elements. The first of these was that the Christian soldier must have the proper disposition toward the enemy—a disposition of corrective love. While it was true that any war waged by Divine command was a just war, the Christian was always a sorrowful and even agonized participant because he was commanded by Christ to love his enemies. Thus even while punishing the sin, the Christian magistrate still attempted to love the sinner and to achieve a just peace at the earliest moment.

Second, St Augustine realized that sometimes even within a Christian Empire an unrighteous ruler might arise. In such a situation the soldier must still obey his orders "because his position makes obedience a duty."[36] St. Augustine did not have a subjective theory of war crimes but rather a monarchical view of law and order which excused those who were merely "following orders."

Third, in any given conflict the absolute righteousness of one side over another may be hard to determine. In such cases, St. Augustine employed the relative theory that one side must be "more just" than the other side. It then became the duty of the Christian to support the lesser of the two evils.

Fourth, in the event it became impossible to separate the innocent from the guilty in the heat of battle, all may be punished, even killed, for the sins of the unrighteous side. This theory of collective punishment was partially rationalized in the thirteenth century by St. Thomas Aquinas' rule of "double effect." If one attacks a city and unintentionally kills the innocent while striving to punish the guilty, such an act is not a cardinal sin.

Finally, St. Augustine allows for "chastening of heretics."[37] Labeling a heretic a rebel against the authority of God, and therefore of the Christian state was but a short step in the Middle Ages to regarding all rebels as heretics. Indeed, a heretic was defined as anyone contemptuous of ecclesiastical authority which was, of course, the basis of secular authority as well. Thus any dissent even to an unrighteous law could, and did, result not only in an inquiry but also in an Inquisition.

[34]Van Der Meer, *Augustine the Bishop* (New York: Harper Torchbooks, 1961), pp. 163-64. See also Paolucci, p. 190ff.

[35]Bainton, p. 93.

[36]St. Augustine, *Contra Faustum*, XXII, 70, 75 as cited in Bainton, pp. 56-57.

[37]F.H. Russell, p. 25.

Transition to Grotius

Another contribution and a significant departure from Augustinian thought came in the *Responsa Nicolai ad consulta Bulgarorum* (A.D. 866) by Pope Nicholas I who felt that any defensive war was just. Whereas Augustine had insisted that a Christian may kill only for the sake of his neighbor and out of the intent of love, Pope Nicholas indicated that "one can fight for the defense of oneself, one's country, and of one's laws."[38] Moreover, to refuse such defensive action would be "to tempt God."[39]

St. Thomas Aquinas, professor of theology at the University of Paris, wrote only casually about warfare. In Question XL of the *Summa* which is under the heading of "Charity," Thomas followed Augustine almost to the letter. A just war must have right cause, right authority, and right intention.[40] Needless death and plunder of citizens are forbidden.[41] Clerics should no longer participate in war, for St. Paul said "the weapons of our warfare are not carnal, but mighty through God."[42] No private person may assemble troops and declare a war, but a "public person" may declare "a just war" which "is wont to be described as one that avenges wrongs."[43] Nevertheless, if an innocent person killed unintentionally in a war fought for a just cause, it was simply a regrettable aspect of war itself.

It is rather remarkable that the just war could be covered so objectively by the Dutchman Hugo Grotius (d. 1645), a legal counsellor for the Dutch East Indies Company and "the father of international law." The value of his *De Jure Belli ac Pacis* for a study of the Just War theory and non-combatant immunity is immense, even though Grotius introduced very little in the way of *content* that was original. In fact, Grotius quoted Cicero, Augustine, and Franciscus de Vittoria among other "theologians and doctors of law,"[44] on the theory of justice and war. But Grotius systematically *applied* the principles that he outlined "whether derived from nature, or established by custom and tacit agreement" to "mutual relations among states."[45] Thus Grotius was the first writer since Augustine to draw on both classical law and Scriptural ordinances in order to establish a universal, international code. He was also one of the first to replace the two cities of Augustine and Luther with one society under rational law.

The just war for Grotius was primarily one of self-defense or punishment for damages sustained. "No other just cause for undertaking war can there be excepting injury received."[46] War must have just cause and be waged by the proper authority, "one who holds the sovereign power in the

[38]Tooke, p. 13.

[39]*Ibid.*

[40]Tooke, pp. 21-25.

[41]*Ibid.*

[42]*Ibid.*

[43]*Ibid.*

[44]Francis W. Kelsey (trans.) *Hugo Grotius: De Jure Belli as Pacis* (Oxford: Clarendon Press, 1925), p. 22.

[45]*Ibid.*, p. 9.

[46]Grotius quoted in T.S.K. Scott-Craig, *Christian Attitudes to War and Peace* (New York: Charles Scribner & Sons, 1938), p. 137.

State."[47] A just war, in order to be a moral one, must also be fought justly, with no punishment for the innocent unless "we are able in no other way to protect our life and property."[48] The one exception to the rule of non-combatant immunity for Grotius, therefore, was the right of military self-defense, that is, when civilians unlawfully threaten the safety of the "just forces," the forces may regard them as a legitimate target.

From Limited War to Total War; The Shifting Emphasis Within the Just War Theory

By the end of the seventeenth century, the Just War theory had passed through the religious wars of the Reformation into the age of the scientific Enlightenment. Eighteenth century warfare was influenced by the Rationalists, the rise of the study of international law, the preoccupation of the European nations with colonialism, the emigration of dissident elements from Europe, the practice of paying armies rather than allowing them to plunder freely, and, above all, the rise of the merchant class to power.[49] Emphasis was on the growth of economic trade and industry protected by professional armies. Thus, the eighteenth century was one which regarded it imprudent "to wreck a market" even when destroying a rival's trade.[50]

The Just War theory became, therefore, an important mechanism for limiting the damage that warfare produced and stressed, as a result, the *just conduct* of war as much as, if not more than, the *just cause* of the conflict. Vattel in his 1758 edition of *The Law of Nations*, which was read by Benjamin Franklin and John Marshall and which became the standard authority on the subject of international law throughout the period of the American Revolution, suggested that for diplomatic purposes wars between sovereign nations might be regarded as "just" on both sides. He thereby deemphasized the "war guilt" aspect of the Just War theory in favor of a "no fault" war. John Locke, in his *Second Treatise on Civil Government*, suggested that demands for reparations be strictly limited to an amount proportional to the damage suffered by the victorious side. Just conduct in war which stressed the principle of proportionality would then hopefully prevent the bitterness of defeat in one war from breeding yet another conflict. Finally, Immanuel Kant suggested a federation of nations to handle international disputes in order to prevent minor injustices from erupting into major confrontations.

On the battlefields themselves military commanders in the mid-eighteenth century attempted to civilize the conduct of warfare even further. The British General James Wolfe promised the citizens of Canada in 1759 immunity from harm and plunder as long as they did not interfere with the operations of his army. General George Washington had "paragraphs of the Military Law" read to the regiments in the Continental Army of 1775 every Monday morning while his 218 Army chaplains encouraged the troops to remain

[47] *Ibid.*, p. 138.
[48] Kelsey, p. 723.
[49] Bainton, p. 184.
[50] *Ibid.*

faithful to their just cause and to their American commanders.[51] Most of the British commanders during the American Revolution, including Clinton and Cornwallis, treated the people of occupied Boston, New York, Philadelphia and Charleston relatively humanely in comparison with the Tories who operated in more or less guerrilla fashion without regard for *The Law of Nations*.

There were, therefore, no new elements added to the theory of the Just War during the eighteenth and nineteenth centuries, but as Professor James Turner Johnson has observed, "till the period between the two World Wars, the just war ideas were carried on and further developed largely in the spheres of international law and military thought. This led inevitably to a narrowing of focus according to the interests of these fields."[52] The theory of the Just War did not disappear, but those writers in the nineteenth century who commented upon it usually did so within the context of new and massively efficient weapons and methods of military mobilization. Those commentators came to regard the survival of the country as the highest priority, more important than following the letter of the military law which regarded all non-combatants as immune from deliberate attack. The just conduct provision of the Just War theory yielded to the industrialization of warfare with its longer range weapons and revised theory of targeting railheads and food storage areas. In both America and Europe warfare became mechanized and was waged by what some historians later called a "race of mechanics." President Ulysses S. Grant stated bluntly by 1886, "The armies of Europe are machines . . . the majority of the soldiers in most of the nations of Europe are taken from a class of people who are not very intelligent and who have very little interest in the contest in which they are called upon to take part."[53]

In the face of the increased potential for destruction in modern warfare, the civilized nations of the world initiated a series of conferences designed to limit warfare by international compact. The first Red Cross Convention met in 1864 and the Hague Convention in 1899. Yet, as Professor Geoffrey Best has shown these conferences had only limited success for a wide variety of reasons.[54]

Nevertheless, the early twentieth century saw at least the verbal recognition of the Just War theory by most religious confessions. The Thirty-Nine Articles of the Church of England contained the clause, "it is lawful for Christian men to wear weapons and serve in just wars."[55] The Presbyterian Westminster Confession spoke of wars that "are just and necessary," and the Lutherans fell heir to similar ideas in the Augsburg Confession.[56] In short, as Professor Paul Ramsey has noted, the Just War theory became the common teaching, in one version or another, of all non-sectarian Christian traditions.[57]

[51]Colonel Aaron Barlow's *Book of Orders*, 17 June 1977 in the Rare Books Section, USMA Library, West Point, New York.

[52]James T. Johnson, *Just War Tradition and the Restraint of War* (Princeton, NJ: Princeton University Press, 1981), p. 326.

[53]U.S. Grant, *Personal Memoirs* (London: Low and Rivington, 1886), II, 531.

[54]Geoffrey Best, "Restraints on War by Land before 1945," in Michael Howard, (ed.) *Restraints on War* (London: Oxford University Press, 1979), pp. 67-75, 27-36.

[55]Moellering, p. 59.

[56]Paul Ramsey, *The Just War* (New York: Charles Scribner's Sons, 1968), P. Xii.

[57]*Ibid.*, p. xv.

Insofar as the main Christian confessions had a "theology that imposed limits upon war," it was found in the Just War theory.[58]

There has been general agreement among most modern ethicists that the criteria for the Just War theory in mid-century included ten key ideas:

1. That all other means to a morally just solution of conflict must be exhausted before a resort to arms can be justified.
2. That war can be just only if employed
   a) to defend a stable political order or a morally preferable cause against a real threat or b) to restore justice after a real injury has been sustained.
3. That war must be waged with the attitude of magisterial correction rather than malicious revenge.
4. That a just war must be explicitly declared by a legitimate authority.
5. That a war have a reasonable chance of success.
6. That certain parts of the population, especially noncombatants, be immune from intentional attack.
7. That the damage likely to be incurred by the war may not be disproportionate to the injury suffered.
8. That only legitimate and moral means may be employed in prosecuting the war.
9. That the final goal of the war must be the reestablishment of peace and justice.
10. That negotiations to end the war be in continuous process as long as fighting continues.[59]

It did not take serious thinkers long to realize, however, that the environment created by using nuclear weapons in World War II and by stockpiling them thereafter directly challenged the applicability of some Just War criteria. In particular many ethicists realized that the use of nuclear weapons, by definition, would preclude to some degree the application of the Just War criteria of discrimination and proportionality. The damage incurred by the use of such weapons even in a limited area would probably destroy some of the very territory which the combatants were fighting to protect.[60]

A Crisis of Relevance: Just War Issues in The Modern World

The deaths of fifty-one million people during World War II, partially as the result of using nuclear weapons, highlighted the inadequacy of international

[58]*Ibid.*, p. xiii.

[59]A synthesis of ideas from Edward L. Long, Jr., *War and Conscience in America* (Philadelphia: The Westminster Press, 1968), pp. 24-32; Joseph C. McKenna, S.J., "Ethics and War: A Catholic View," *American Political Science Review*, LIV (September 1960), 647-658; and Roland H. Bainton, *Christian Attitudes Toward War and Peace*, pp. 36-42, 89-100.

[60]Laurence Martin, "Limited Nuclear War," in Michael Howard (ed.), *Restraints on War*, pp. 103-120.

restraints on war and virtually mandated a revived effort to limit warfare more fully. The "no fault" wars of eighteenth century diplomats were obliterated by the Blitzkrieg, the Holocaust, and the Nuremburg and Tokyo War Crimes Trials. The theory of "war guilt" returned with a vengeance.

Aggressive war was now clearly unlawful, censured by the United Nations Charter and the Geneva Conventions. Collective security agreements involving more than fifty nations, such as the North Atlantic Treaty Organization, the Rio Pact and the Southeast Asia Treaty Organization, sought to ensure that such global aggression as that exhibited by the Axis Powers in World War II would not be repeated. Such aggression could not be repeated because it was only barely survived by the civilized nations of the world.

The efforts to limit warfare in its causes and conduct after World War II generally followed two tracks: legal restraints by treaty and protocol to limit the development, testing and employment of high technology weapons and diplomatic measures to resolve conflicts in both developing and industrialized nations. Nevertheless, since World War II the United States has been a party to conflicts involving twenty-five nations. Some 518,000 Americans have been killed, wounded, or lost in undeclared wars or police actions since 1945. Clearly the challenges to peace with justice in the world have not disappeared.

Moreover, the proportion of civilian to military casualties in modern wars has risen above fifty percent in almost every case. The table illustrates this increase as a result of the employment of high tech weapons coupled with attrition strategies and tactics (see table on next pages).

Recent examples of casualties incurred even in low intensity conflict, such as in Operation Just Cause in Panama, show that in urban area fighting civilian casualties may constitute more than sixty percent of the total, no matter how careful commanders might be in the employment of their units and weapons. Such high civilian casualty rates have a direct impact on many important factors including world opinion, public support for the operation, troop morale, the quantity, quality, and duration of health care which may be provided in such circumstances, and the ability of all parties to rebuild a peaceful society after the conflict is over.

Two ominous trends which have made the application of Just War criteria difficult in the last quarter century center on the arming of the Third World nations with quantities of sophisticated weapons, and the continuing revolutions, revolts, and terrorist movements which have erupted in Asia, Latin America, and the Middle East over the same time period. As of January, 1990, twelve Third World countries were known to have more than one thousand main battle tanks and long range chemical and missile capabilities.[61] Of the 1,870 terrorist incidents reported in the world in the first two quarters of 1988, 1500 involved some of these same Third World countries.

The application of strict Just War criteria to modern warfare, with its incredibly wide range of options and contingencies, is extremely difficult without tying the hands of those responsible for our collective defense.

[61]Helen C. Metz (ed.) *Iraq: A Country Study* (Washington, D.C.: U.S. Government Printing Office, 1990), p. xxix.

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Scholars such as Professor Paul Ramsey and Professor Theodore Weber who sought to "recapture the just war" theory for the modern world or at least to show how its relevance could be recovered, tended to shift its application from the battlefield to the arenas of politics and diplomacy. Professor Weber wrote:

> The just war criteria have a new and more comprehensive role in the modern context of the conduct of foreign policy. Traditionally they were used to judge actual and prospective uses of military force . . . Now, however, the assumptions themselves have been undermined, and with that change in operating conditions the primary role of the just war criteria has become that of providing guidelines for the recovery of the assumptions. All foreign policy deliberation and execution—all forms of national power and not only military power—are put under the discipline of promoting the restoration of the operational status of the just war assumptions.[62]

Secretary of Defense Caspar Weinberger thought in similar terms, for in 1984 he emphasized that the responsible use of military force was a moral issue. Secretary Weinberger outlined six tests of an ethically defensible engagement in warfare:

1. The goal of the military operation must be vital to our national interests.
2. We must be able and intend to win.
3. We must have clear objectives.
4. We must provide the forces to reach our objectives.
5. We must have the support of Congress and the people.
6. Our military and our use of such power must be a last resort.

Although Weinberger's tests fell short of replicating the full Just War theory, they did include enough elements of it to serve as the basis for media evaluation of the ethical issues in Operation Just Cause in Panama in 1989, and for Operation Desert Storm.[63]

Hope for the Future

The history of the ethics of warfare is a record of efforts by many people: philosophers, theologians, jurists, statesmen, and military leaders among them, to establish values and rules by which the devastation of war may be limited. For most, including some of America's most capable military and political leaders, warfare as an instrument of policy must be minimized and hopefully someday abolished.[64]

What values future ethical systems will emphasize is not easy to predict; but most of the elements of the Just War theory, including the principles

[62]Theodore R. Weber, *Modern War and the Pursuit of Peace* New York: The Council of Religion and International Affairs, 1968), pp. 28-29.

[63]P.J. Budahn, "Doubters Aside, Panama Decision Feels Right," *Army Times*, January 1, 1990, p. 63.

[64]See statements by General Douglas MacArthur and Dwight D. Eisenhower in V.E. Whan (ed.) *A Soldier Speaks* (New York: Frederick A. Praeger, 1965) p. 270 and Allan Taylor (ed.) *What Eisenhower Thinks* (New York: Thomas Y. Crowell, 1952), pp. 91, 97.

of proportionality and discrimination, remain relevant for both military and diplomatic application. There are more international treaties, conventions, restraints, and laws of warfare on the books than at any previous time in history. Yet there are more highly developed weapons at the disposal of nations undergoing violent change than at any previous time as well.

General Sir John Hackett, co-author of *The Third World War*, wrote that:

> We may well be working towards a position in which the main purpose of the profession of arms is not to win wars but to avoid them. If this is so, the chief function of the armed forces now becomes the containment of violence.[65]

Surely such a mission has been evolving in many areas of the world with the support of more than a hundred nations since World War II. If it is successful, perhaps all of the members of the military profession, including the members of health care teams, may witness a new age when "nation shall not lift up sword against nation," and the study of war shall be incidental to the maintenance of world stability, justice, and peace.[66]

[65]As cited in Malham M. Wakin, *War, Morality and the Military Profession* (Boulder, Colorado: Westview Press, 1979), p. 95.

[66]Isaiah 2:4.

Ethical Principles and the Practice of Battlefield Health Care

Michael E. Frisina

Introduction

In Plato's *Theatetus*, Socrates admits that he is a practicing midwife. He pleads to his young interlocutor, "you must not give me away to everybody else. It is the one thing people do not say about me, because they do not know. What they do say is that I am very odd, and that I make people feel difficulties."[1]

Socrates' allusion to his being a midwife is metaphorical. "My art of midwifery is different in that I attend to men and not women, and that I watch over minds in childbirth and not bodies. And the greatest thing in my art is this: to be able to test, by every means, that the young man's intellect is giving birth to something genuine and true."[2]

Socrates practiced his art with zeal. His methodology, incessant questioning of people who believed to have knowledge about something, ultimately led to his arrest and execution. Like Socrates, I want to cause you difficulties with issues perhaps long settled in your minds. My goal is to motivate you to think critically about the ethical problems associated with battlefield health care and guide you through a process which will help resolve those problems.

Before we move on to ethical discussions about battlefield health care, we need to confront two potential problems. The first problem is the tendency to think that the issues before us are too difficult and that our perspec-

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[1]Plato. *Theatetus*. McDowell, John, trans. Oxford: Oxford University Press, 1978. 11.
[2]Ibid. 13.

tives, be they medical, philosophical, or theological, are too diverse to find adequate resolutions.

The second major problem centers on the differences with our emotions—how we *feel* about certain issues. The power of our emotions may dominate our ability to reason clearly. I do not mean to imply that the nature of ethical discourse is exclusively conceptual and logical. My concern is the tendency to let emotion dissuade us from accepting conclusions that plague us emotionally.

These problems should not discourage us from raising ethical issues about combat health care nor should they keep us from seeking adequate solutions for these issues. Though our perspectives are diverse, there is a critical thinking methodology to narrow that diversity. As I mentioned earlier, however, we need not become a slave to conceptual and logical reasoning. Our emotions are as vital to our humanness as reason, and the emotions can tutor our reasoning capacity.

Accepting the premise that it is possible to identify ethical issues related to battlefield health care, the first part of this essay addresses the nature of ethical discourse. Part two introduces the reader to ethical analysis and the principles presently guiding ethical decisions in health care. Finally, having discussed the theoretical components of ethical analysis, part three will look at examples of ethical conflict in battlefield health care and the application of ethical analysis to resolve such conflict.

The Nature of Ethical Discourse

The distinct quality of ethical discourse originates in the types of statements we make about human activity. The statement "George Washington was the first president of the United States," is a factual claim devoid of any moral content. The statement "George Washington should not lie," is a normative statement. Normative statements express a value judgment of some kind whose correctness we determine by making reference to some standard. The claim "Mozart was a great composer," is a normative statement whose correctness is based on an aesthetic standard while the claim, "telling lies is wrong," is a normative statement whose correctness is based on a moral standard—an ethical principle.

Ethical conflicts arise in daily living when moral judgments we make about human conduct differ from those of other people. Such conflict illustrates a clash of moral values. When forced to defend their moral judgments, people appeal to some higher standard—an ethical principle. For example, in the claim, "Murder is wrong," how would we respond when challenged to defend that claim? Inevitably, we make an appeal to some moral standard or ethical principle. In the case of murder, there might be several such principles that support our judgment. We could say murder violates the personal autonomy of the victim. We might argue that murder is a violation of the victim's human rights or violates the notions of equality and justice. We could also appeal to the consequences of performing such an action. In essence, ethical principles serve as justification for the moral judgments we make about human conduct.

This process of moving from moral judgments to higher level ethical principles to defend those judgments is what philosophers call moral reasoning. Moral reasoning is a complicated process. Bioethicist Ruth Macklin states, "Ethical conflict ultimately develops when two people make contradictory claims, appeal to different ethical principles for justification, each when considered by itself is unassailable."[3]

Such conflict is inevitable in a society like that of the United States where differing social, ethnic, and racial groups adhere to differing values. Hence the origin of ethical conflicts in military medicine stems partially from 1) the pluralistic nature of our society which lacks moral homogeneity (what one ethicist calls "a collective moral life") and 2) the rapid development of biomedical technology of the past thirty years complicating the practice of the health care professions.

Much has been written about the pluralistic nature of our society. Such diversity of belief has spawned skepticism about whether anything we might call moral truth exists. Moral skeptics doubt that questions of an ethical nature have answers that extend beyond a person's intuition. I disagree. While there may well be a diversity of perspective on ethical issues, some positions are more plausible and reasonable than others. Blessed with the capacity to reason, our task is to seek the best answers possible using the tools of rational analysis and ethical theory.

Ethical Analysis

Historically, ethical theories have developed as a result of philosophers seeking a means to effect change in the societies in which they lived. Each ethical theory is built around some ethical principle. We have already mentioned several of these principles in our earlier discussion of the components of moral discourse. In applying an ethical theory to a particular action to determine whether such action is morally right, we ask whether the action violates the ethical principle of the theory we are using. If, in our analysis, the action violates the ethical principle, that action is morally wrong. Hence, when we say that "murder is morally wrong," we mean that murder violates an ethical principle embodied in the ethical theory we are using to analyze the action.

This example raises a problem. By definition or conceptual understanding, murder means wrongful killing. Hence the statement "wrongful killing of a human being is wrong," is a tautology. What happens when we say "killing a human being is wrong."? Then we raise ethical questions about capital punishment, war, and abortion. Is abortion wrong? Yes, if you consider the fetus a human being deserving the protection of the law against wrongful killing. No, if your definition or conceptual understanding for a fetus is less than the status of human life deserving full protection or if equal in status to a pregnant woman, you believe competing claims weigh in favor of the pregnant woman to terminate her pregnancy.

[3]Macklin, Ruth. "Ethical Principles, Individual Rights, and Medical Practices." *National Forum* Fall 1989: 25-27.

The preceding discussion illustrates the complexity of ethical analysis. There is more to pronouncing a moral judgment on an action than merely asking whether that action violates an ethical principle. An ethical principle is the central feature of an ethical theory but only one aspect of ethical analysis. In *Applying Moral Principles*, philosopher C.E. Harris states that besides ethical issues, ethical analysis contains conceptual issues and factual issues.[4] As I have just demonstrated, conceptual issues are often the most prominent aspect of ethical debate. They surfaced last year with respect to the Robert Mapplethorpe photographic exhibition and the lyrics of various rock groups with conceptual differences surrounding legitimate, artistic expression and a conceptual understanding of obscenity.

Factual issues are also important in ethical analysis. Often what appears to be an ethical conflict is a misunderstanding about the facts surrounding a particular action. Every moral problem contains factual issues relevant to the moral judgment of an action. Factual issues are the first things people ask for when working an ethical case study. The hope is that if we just know enough about the situation then the moral issues will become readily apparent. Awareness of these various aspects of ethical analysis can help us to see more clearly about an action and the judgment we ultimately render regarding its moral status.

To this point, we have been discussing the structural framework of ethical analysis without getting into the details of any one specific theory. In sum, I have shown that an ethical analysis is a systematic and ordered process. The highest level in this systematic process is the ethical principle; the lowest level is the judgement that a certain action X is morally wrong. At various levels between the top and bottom are the factual and conceptual issues relevant to a particular ethical theory. Having an understanding of ethical analysis in general we can now discuss the two dominant ethical principles at work in medical ethics today—the principles of beneficence and autonomy.[5]

The term beneficence suggests acts of mercy, kindness, and charity.[6] As a moral principle, beneficence asserts a positive moral obligation (something you must do) to help others. Hence this principle might obligate a person to donate blood and organs to save a life. One might be obligated to donate money to medical charities. In applying the principle of beneficence to particular actions, a decision maker must weigh in the balance those actions likely to produce the best consequences, where the best consequences promote the greatest good while preventing or removing harm.

As an ethical principle, the term autonomy refers to the notion of "respect for persons." This principle recognizes each individual as having dignity and intrinsic self-worth. The concept of self-worth derives from a conceptual understanding of what it means to be a human being: possession of goals,

[4]Harris, C. E. *Applying Moral Theories*. Belmont, CA: Wadsworth, 1986.

[5]A complete discussion of ethical principles is too long for this paper. I encourage the reader to consult the sources listed in the bibliography for a more detailed introduction to ethical theories.

[6]Beauchamp, Tom L. and James F. Childress. *Principles of Biomedical Ethics*. 3rd ed. New York: Oxford University Press, 1989.

desires, and rational agency—that is a free agent capable of making rational decisions for oneself. This concept generally applies to adult decision makers. Autonomy also extends to children and other adult family members who, lacking the ability, are unable to make rational choices.

Traditionally the principle of beneficence and the principle of autonomy have stood in opposition to one another. The center of the opposition between them is the concern over the consequences of our actions. The determining criteria regarding the autonomy principle is the choice of the individual regardless of the consequences. The principle of beneficence has an absolute requirement that only those actions that produce more benefit than harm are the morally right actions and to do otherwise is to act immorally. Hence in the words of philosopher Joseph Fletcher, "if the ends [consequences] do not justify the means [action] what does?"

The problem with employing the principle of beneficence as the sole criteria for moral conduct means that no other characteristics of an action have any bearing on whether that action is morally right. Arguably there are other characteristics, not the least of which, concern about the equitable distribution of benefits from an action. Hence, while producing good results is relevant to resolving moral conflict, it is not absolute. While in many cases doing an action that produces benefit may be morally commendable, such an action need not be morally obligatory. That statement may apply in a general sense but what about in special cases like the military?

Ethical Conflict and Battlefield Health Care

Technological advances in weapons development means that the number and types of wounded soldiers on the modern battlefield will likely overwhelm the battlefield health care system.[7] Consequently, much of the ethical conflict in battlefield health care will stem from the responsibility of care providers to "conserve the fighting strength," while simultaneously trying to uphold the individual interests of wounded soldiers. We need not contrive hypothetical cases to demonstrate this conflict. The following anecdote appears in T.R. Fehrenbach's *This Kind of War*:

> On 30 November, the medical convoy was still stopped on the road miles north of the pass. . . . It grew darker, and the thermometer fell. . . . Then an officer ran along the stalled line of trucks, shouting, "It's every man for himself! We're trapped! Get out any way you can." Men got down from their trucks and began to run for the circling hills—the officers and sergeants followed. Here, thought Sergeant Schlichter later, we committed a grievous error. Here we broke faith with our fellow soldiers, and fellowmen. There were 180 wounded men in the trucks, and no one said anything to these men as they were abandoned.[8]

Many of the issues we have already discussed surface in this short quotation. The factual issues put the story in perspective. A medical unit is

[7]For an apt description of a likely scenario see: Swann, Steven W. "Euthanasia on the Battlefield," *Military Medicine*, 152: November 1987, 545-549, reprinted in this issue.

[8]Fehrenbach, T. R. *This Kind of War*. New York: Macmillan Publishing Co. 1963, 346-347.

participating in an orderly withdrawal. Caught in an enemy envelopment, the convoy is unable to move south to friendly lines. As Fehrenbach tells us, "the men became tried and cold and scared. . . . Panic began to sprout."[9] The commander lost control of his unit. He was unable or unwilling to order any one directly, or seek volunteers, to stay with the wounded. "The two hundred-odd men of the company spread all over the hills. All knew they had to go south—but none of them knew where south was in the dark."[10]

The moral issues are the main element of our analysis. There are the traditional military virtues of duty, courage, integrity; traditional character traits like competence, and commitment as well as the notions of self-interest and utility come into play. While making these theoretical distinctions is an important part of ethical thinking, they do not help us understand why this event occurred. What was it about the soldiers themselves, their education, their upbringing, their institutions—the elements of their lives encompassing who they were as moral agents that compelled them to commit this act?

These are the important questions and we need to think about them when we are at peace because the stress, the horror, and the panic of modern day combat will allow for the contemplation only after the fact, not while one is in the midst of the conflict. Therefore, we need to ponder about what sort of people we produce in our military medical training programs. Much to the credit of the Army Medical Department, ethics instructions cuts across all branches. Unfortunately, there is no guarantee that teaching people about ethics makes them act ethically. Ethical conduct is the product of character and character development does not happen in the lecture hall but at the bedside, in the foxhole, in the check-out line—when how we choose to act reflects what kind of moral agent we happen to be.

If what you choose to do is inextricably linked to who you are as a person, then we can look back at the Korean War anecdote and ask ourselves what might we have done in a similar situation? For example, would it have been acceptable for the commanding officer to order some soldiers to stay with the wounded while the remainder of the company tried to contact friendly lines? If so, what criteria do you use to choose which soldiers you order to stay? Would you ask for volunteers before ordering anyone to stay? What if you get more volunteers than are necessary. Would you order someone to leave the convoy when that person truly desired to stay with the wounded? Speaking of the wounded, do you tell them the truth about your situation or make up a story for those who ask why you have stopped? Do you have an obligation to tell the wounded soldiers the truth? Take some time to think about these questions before you continue to read.

I hope you were able to make some choices about the questions above. If asked how you chose in a particular case, what ethical principle(s) would justify your responses? Before you get comfortable with your answers let me give you some additional facts. In the early part of the Korean War, the North Koreans did not take prisoners. The North Koreans did not observe the protected status of medical personnel treating all uniformed soldiers as

[9]Ibid. 348.
[10]Ibid. 348.

combatants. How does this additional factual information change the responses you made to the above questions? The North Koreans will kill any person who stays with the convoy. Medical personnel are a limited resource on the battlefield. Greater *benefit* will be served if as many members of the company survive to continue providing medical care to future wounded soldiers then to stay with the wounded of the convoy and face certain death. Would a company commander be justified in abandoning these patients under the known circumstances? Let me go one question further—if you choose to abandon the patients, would you be justified in actively euthanizing them so they die painlessly as opposed to suffering at the hands of a cruel and heartless North Korean enemy?[11]

Recall that our purpose in working through this example was to see the conflict of values that will occur in the midst of providing battlefield health care. At this juncture I hope you are not waiting for me to give you the "school book solution." Remember my purpose was to cause you problems—I never promised to solve them for you but to give you a methodology for working out your own answers. I do not mean to imply that any answer you derive is acceptable. Certainly there is greater justification in abiding by the operative values of the military and society in general, then there is in playing the moral maverick.

My main concern is that you wrestle with the conflict and come to some conclusion based on analysis of all the ethical components we discussed. Morality concerns itself with the rightness and wrongness of actions of moral agents. You cannot allow the fear of uncertainty about the rightness or wrongness of your actions keep you from choosing to act. Such a concern exhibits a tension between making the absolutely right choice as opposed to making the best choice given all the available information and reasoned ethical analysis. Erich Lowey, professor of medicine at the University of Illinois states.

> Physicians accept fallibility in technical matters as a condition of medical practice. When it comes to moral decisions, physicians are often loathe to act without a good deal more certitude and seem less willing to accept error. . . . Moral virtue resides in the making of a decision and in the agony of making it than it does in the potentially fallible decision itself.[12]

This same concern over indecision comes from General Thomas J. Whelan, Jr. In his preface remarks to the 1988 edition of *Emergency War Surgery*; *NATO Handbook*, Whelan states "combat surgeons need good hands, a stout heart, and not too much philosophy."

Conclusion

One last question that requires asking is what do we do when after having gathered all the known facts and making all the ethical distinctions, it appears

[11]I am aware that current doctrine states that medical personnel will not abandon patients on the battlefield. I also am aware that from a legal perspective, active euthanasia of a wounded soldier, be they friendly or foe, would constitute premeditated murder. Nonetheless, we need to ask what is the rational basis for such doctrine and if alternative actions have ethical justification.

[12]Lowey, Erich. "The Uncertainty of Certainty in Clinical Ethics." *The Journal of Medical Humanities and Bioethics* Spring/Summer 1987: 26-33.

we have an irresolvable conflict? One important aspect of ethical analysis is identifying the interests of those likely affected by the decision. How will you choose in your personal or professional interests are part of the analysis? How will you remain impartial to your own interests? Often we misconstrue what we understand to be an ethical conflict when what we are seeking is justification to choose in such a way that serves our own self-interest. Traditionally, in these conflict of interests cases, we expect the decision maker to opt out of making any decision at all. Other times, and most often for the military professional, we resolve such conflict serving the interest of the military. We often do so with great reluctance and emotional turmoil. Nonetheless, the ethical analysis process we have discussed and applied to a real situation will help you in making ethical choices you face as a military health care provider. Your alternative to this methodology is not to avoid making these choices, but to avoid making them in a fit of panic, making them randomly, and making them devoid of rational deliberation.

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The Ethical Basis of Military Medicine in Peace and War

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Introduction

This paper is not presented as a comprehensive treatise on either the ethics of war or medical ethics. It is an attempt to provide a basis for further study and discussion of the interrelation of these subjects in the hope that a codified system of military medical ethics for peace and war will be developed. Religion and philosophy have had considerable influence upon moral and ethical concerns about war and medicine for nearly four millenniums.[1] In recent decades secular influences have become more prevalent, reflecting the growing pluralism of modern societies and the virtual explosion in technological advances in both medical science and the implements of war.[2]

Within the last half century, and especially within the last 20 years, the literature of the ethics of war and of medical ethics has greatly expanded. Since 1973 there have been some 675 books and monographs on the morals and ethics of war.[3] Pellegrino and Thomasma, in 1981, reported that over

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[1]Thomas A. Mappes and Jane S. Zembaty, *Biomedical Ethics* (New York: McGraw-Hill Book Company, 1986), 54. The authors cite the Oath of Hippocrates, fifth century B. C. Robert M. Veatch, *A Theory of Medical Ethics* (New York: Basic Books, Inc., Publishers, 1981), 56. Reference is made to the Babylonian Code of Hammurabi, 18th Century B.C.

[2]Ray Branson. "The Secularization of American Medicine" in *On Moral Medicine*. Stephen E. Lammers and Allen Verhey, eds., (Grand Rapids, MI: William B. Eerdman Publishing Company, 1987), 24-32.

[3]John W. Brinsfield. Ethical Theories of War. Part 1. Presented at "Medical Ethics and the Health Care Provider on the Battlefield" Conference, May 1990, San Antonio, Texas. Videotape.

200 articles a month on medical ethics were authored by representatives from a wide variety of disciplines.[4] The American College of Physicians Ethics Manual published in 1989 contains an annotated bibliography of nearly 200 recent articles on medical ethics.[5]

Ethical concerns about military medicine must be viewed in the context of both the ethics of war and the broader societal issues of medical ethics. Religious, philosophical, and secular influences on the evolution and current positions of both ethical systems must be considered in developing a meaningful model.[6] We use the terms moral and morals to refer to decisions and actions based on rules and principles of behavior, i.e., whether decisions and actions are right or wrong, good or bad. Ethics is a philosophical discipline used to establish theories to develop the basis of moral judgment or to examine why a certain decision or action is right or wrong, good or bad. In applied ethics, there are few absolutes. Moral individuals applying identical ethical rules to solve similar moral dilemmas may reach significantly different decisions about what constitutes a proper course of action.[7]

Of all species on earth, only mankind wages war. Man must know intuitively that wars are inevitable and that there is something inherently wrong about the organized killing and destruction that are the consequences of war. It should not be surprising that scholars, philosophers, and religious authorities over the centuries have sought to establish a moral code of warfare which, at best, defines conditions under which war can be legitimately justified and conducted, or which, at worst, is a rationalization for the participation of moral men in the killing and destruction caused by war.

Just War Theory

While there are a number of historical theories of warfare to include holy wars, crusades, limited war, total war, and others,[8] we will limit our discussion to the Just War Theory. The principles underlying the Just War Theory can be traced to the Greco-Roman period, probably beginning with the Peloponnesian wars of the fifth century B.C. Earlier wars had generally resulted in total destruction of states, wholesale massacre of populations or, at best, death of all of the defeated combatants and a subsequent life of slavery for the survivors of the vanquished. The writings of St. Augustine and St. Thomas Aquinas introduced the concepts of discrimination and proportionality in the conduct of war.[9] While Greek thinkers enunciated the principles of just war, they failed to systematize the concept as an organized ethical theory. It remained for the Romans to introduce the concepts of just cause for war,

[4]Edmund D. Pellegrino and David D. Thomasma, *A Philosophical Basis of Medical Practice* (New York: Oxford University Press, 1981), 170.

[5]*Ann Intern Med* 109:775-776,1988, Editorial

[6]Tom L. Beauchamp and Laurence B. McCullough, *Medical Ethics* (Englewood Cliffs, NJ: Prentice-Hall, Inc., 1984), 8-13, 26.

[7]Mappes and Zembaty, 41.

[8]Brinsfield.

[9]Raymond A. Shulstad, *Peace is My Profession* (Washington, DC: National University Press, 1986), 25-28.

"jus ad bellum," and just conduct of war, *"jus in bello."* The codification of the Just War Theory came to include the requirement that war must be waged only as a last resort, that it be preceded by adequate warning, and that it must be formally declared. Even after war was initiated, negotiations were always possible to establish peace and satisfy requirements for justice. Additional features of just war included that combatants be clearly distinguishable from noncombatants, a condition that has not been observed in some recent conflicts. As Rousseau states in *The Social Contract*, "War is something that occurs not between man and man, but between states. The individuals who become involved in it are enemies only by accident. They fight not as men or even as citizens, but as soldiers; not as members of this or that national group, but as its defenders." Rousseau equates the ruler who wages unjust war to the robber or pirate who extorts by unlawful force.[10]

In the period following the fourth century A.D., the influence of Christian theology in the writings of St. Augustine, St. Athanasius, St. Ambrose, and later St. Francis introduced additional features to the Just War Theory based upon religious principles.[11] These included such views as exoneration of combatants who were merely following orders (a position clearly overturned at the Nuremberg trials following WW II)[12] and the theory of collective punishment. In this latter theory, it was tacitly acknowledged that distinguishing combatants from noncombatants in the heat of battle was not always possible, leading to injury and death in both groups. It is worth noting that in many wars casualties among noncombatants have been far greater than for combatants.[13] St. Thomas introduced the concept of double effect in which the undesirable effect of an action was acceptable as long as it was unintended and was outweighed by the good effect. Similar moral notions are to be found in systems of medical ethics.

In the 17th century, the Dutch legalist, Hugo Grotius,[14] further amplified the features of just war and distinguished for the first time between what is permitted, tolerated, or perhaps rationalized in war by usage or custom, e.g., accidental killing of noncombatants and what is morally acceptable. For these and other contributions, Grotius is considered the father of international law. As the law of war evolved, it became apparent that only the law, and not morality, allowed for sanctions, i.e., punishment for infraction.[15]

Additional refinements and formal attempts to civilize warfare have produced a theory of just war which is generally recognized in the international community. The 10 key components of this theory are:[16]

[10]J.J Rousseau, "The Social Contract" in *Social Contract.* Essays by Lock, Hume, and Rousseau. (Oxford University Press. London: The World's Classics, 1947), 250-251.

[11]Telford Taylor. "Just and Unjust Wars" in *War, Morality, and the Military Profession.* Malham M. Wakin, ed., (Boulder: Westview Press, Inc., 1986), 226-237.

[12]Anthony E. Hartle, *Moral Issues in Military Decision Making* (Lawrence, KS: University Press of Kansas, 1989), 63.

[13]Brinsfield.

[14]Hartle, 59.

[15]Hartle, 70.

[16]John W. Brinsfield, "From Plato to NATO; the Ethics of Warfare," Spring, 1991, *Military Chaplains' Review.*

1. That all other means to a morally just solution of a conflict must be exhausted before a resort to arms can be justified.
2. That war can be just only if employed:
   a. to defend a stable political order or a morally preferable cause against a real threat, or
   b. to restore justice only after a real injury has been sustained.
3. That war must be waged with the attitude of magisterial correction rather than malicious revenge.
4. That a just war must be explicitly declared by a legitimate authority, i.e., the head of state or governing body.
5. That a war have a reasonable chance of success. (Blainey states that war may occur when one of the parties to conflict incorrectly assesses its chance for success and that war may result when one or both parties incorrectly believe that it will be decisive and of short duration.)[17]
6. That certain parts of the population, especially noncombatants, be immune from intentional attack. The law of war holds it illegal for combatants to disguise themselves as civilians. (Such practice was common in Vietnam and was seen during Operation Just Cause in Panama.)
7. That the damage likely to be incurred by the war may not be disproportionate to the injury suffered for which justice is being sought.
8. That only legitimate and moral means be employed in prosecuting the war.
9. That the final goal of war be the reestablishment of peace and justice.
10. That negotiations to end the war be in the continuous process as long as the fighting continues.

Injustice in Wars

It is not difficult to find examples of events in may wars which have not satisfied the requirements of the Just War Theory. Recent or current civil and tribal wars in third world countries seem, at least to the Western mind, to be characterized by atrocities, wanton slaughter, and the absence of constraints other than the application of equal or superior force upon one's enemy. The Jihad, the Islamic Holy War, does not follow the tenets of the Just War Theory. It is a justification for recourse to violence, not to spread the Islamic religion but to defend Islam from its enemies who are traditionally the infidels.[18] The Jihad theory is not restricted to warfare but may include any means of coercion and persuasion according to the circumstances at the time.[19] Furthermore, the concept of self-sacrifice and martyrdom inherent in the jihad is

[17]Geoffrey Blainey, *The Causes of War* (New York: The Free Press Division of Macmillan, Inc., 1988), 35-56.

[18]Hamid Enayat, *Modern Islamic Political Thought* (Austin, TX: University of Texas Press, 1982), 64, 193.

[19]Emmanuel Sivan, *Radical Islam, Medieval Theology and Modern Politics* (New Haven: Yale University Press, 1985), 114, 115.

foreign to the Just War Theory and is deeply imbedded in Islamic mysticism and fatalism.[20] Just as one should know the military doctrine of the potential enemy to avoid being placed at a disadvantage, one must know the ethical and moral views which will govern the enemy's behavior. Despite the views held by certain religious, ethnic, or national groups about what is permissible in war, the military tribunal at Nuremberg following World War II was very explicit. The Conventions of Hague and Geneva are declaratory of pre-existing and well-established laws recognized by all civilized nations. The laws of war are binding on all irrespective of whether a particular government has signed a particular convention.[21] Nevertheless, the combatants on one side must not ignore the values and views of the enemy concerning what is permissible in war, lest they be placed at considerable disadvantage.

Views on Warfare

A number of prominent individuals over the years have expressed views of war which clearly influence the thinking of military ethicists. General George Patton, exhorting his troops to fight and win, and bolstering what some might have considered flagging morale, states, "Americans love a winner. Americans will not tolerate a loser. Americans despise a coward. . . . Americans love to fight. Traditionally, all real Americans love the clash and sting of battle."[22] And yet, Patton, days before his death from injuries received in an auto accident said, "How awful war is. Look at all the rubble."[23]

General Stonewall Jackson declared, "The profession of arms sometimes requires officers to do that which they fear may be wrong, but which they must do for success. War is the summation of all evils."[24] General William T. Sherman remarked, "I am sick and tired of war; its glory is all moonshine. It is only those who have never fired a shot or heard the shrieks and groans of the wounded who cry for blood and vengeance and desolation. War is hell."[25]

The old soldier, General Douglas MacArthur, regarded war as a form of mutual suicide and wanted to outlaw war.[26] Even Eisenhower, despite his success in the European Theater of World War II, said, "I hate war as only a soldier who has lived it can, as only one who has seen its brutality, its futility, its stupidity. War is the least acceptable solution to our problems."[27]

[20]Ibid., 187.

[21]Hartle, 163.

[22]Charles M. Province, ed. General Patton's Third Army speech, June 1944 (San Diego, CA: Province Publishing Co., 1979), 3.

[23]Ladislas Farago, *The Last Days of Patton* (New York: McGraw-Hill Co., 1981), 244

[24]Burke Davis, *They Called Him Stonewall* (New York: The Fairfax Press, 1988), 132, 172.

[25]William T. Sherman, "An Address Before the Graduating Class of the Michigan Military Academy, June 19, 1879," in *Bartlett's Familiar Quotations*, Christopher Morley, ed., (New York: Little, Brown, 1957), 366.

[26]Vorin E. Whan, Jr., ed., *A Soldier Speaks* (New York: Frederick A. Praeger, 1956), 270.

[27]Allan Taylor, ed., *What Eisenhower Thinks* (New York: Thomas Y. Crowell, 1952), 91.

He later called upon society to "remove war from the category of the inevitable into its proper place as an evil subject to prevention."[28]

As recently as June 1989, Major General Marc Cisneros (currently Deputy Commander of III Corps, Fort Hood, Texas), at the commissioning ceremony for ROTC students at St. Mary's University in San Antonio, Texas, said, "Never forget that war is the ultimate stupidity, but that evil men in positions of power must always be confronted. You'll find evil people out there."[29]

Contrary to what some believe, it is apparent that many military leaders would eschew war if given the opportunity to do so. It may well be that discussions of the causes of war and peace are more likely descriptive than analytical."[30]

Destructiveness of War

The influence of technological advances in warfare were alluded to above. Indeed, one may question whether the destructiveness of modern conventional and nuclear arms negates the theory of just war. Operation Desert Storm demonstrated that despite the destructive power of contemporary conventional arms, the selectivity of the "smart" weapons is consistent with the principles of proportionality and discrimination. Shulstad has addressed in depth the concerns about nuclear arms and cites the opinion that the use of nuclear weapons may be inconsistent with the Just War Theory.[31]

The destructiveness of modern weapons has been the subject of considerable concern in recent years, as exemplified in the following two quotations:

> In two ways science is the best friend war has ever had; it has made slaughter possible on a scale never dreamt of before, and it has enormously increased man's capacity to maim and disable his fellow man . . . Within a few years artillery and high explosives, submarines and aircraft have so revolutionized our methods of warfare that thousands are now destroyed instead of hundreds."[32]
>
> "The modern battlefield . . . will be one of intense destruction and greater lethality than previously known . . . (and) the number of casualties will overwhelm and medical support system . . .[33]

Numerous other references could be cited to describe the lethality and destructiveness of modern weapons systems, some of which have not yet been used in combat. In addition, the modern battlefield will be characterized by fluidity of lines and rapidly changing positions, very unlike the traditional

[28]Ibid.

[29]MG Marc Cisneros, cited in Keynote Address, "Medical Ethics and the Health Care Provider on the Battlefield," May 1990. James G. Van Straten, San Antonio, Texas.

[30]Blainey, Preface to the First Edition, IX-XII.

[31]Shulstad, 28.

[32]Sir William Osler, in *The Collected Essays of Sir William Osler* Vol. 1, "The Philosophical Essays," John P. McGovern and Charles G. Roland, eds., *The Classics of Medicine Library* (Birmingham, AL: Gryphon Editions, Ltd., 1985), 325. From an address entitled, "Science and War," delivered at Leeds University Medical School in 1915.

[33]Steven W. Swann, "Euthanasia on the Battlefield," *Military Medicine*, 152:545-549, 1987, reprinted in this issue.

linear battlefield of previous wars. How much more will those on the battlefield be subjected to what von Clauswitz, in his *Treatise on War*, calls the friction of war? He says, "Everything in war is very simple, but the simplest thing is difficult. The difficulties accumulate and end by producing a kind of friction that is inconceivable unless one has experienced war."[34] He also states that the least important persons involved in a battle can cause things to go wrong."[35]

Samuel David Gross, in *A Manual of Military Surgery*, which he dedicates "To mitigate some of the horrors of the Civil War," states,

> It is impossible for any civilized nation to place too high an estimate upon this branch (military surgery) as a branch of the public service. Without the aid of a properly organized medical staff, no army, however well disciplined, could successfully carry on any war . . . No man of any sober reflection would enlist in the service of their country if they were not positively certain that competent physicians and surgeons would accompany them on their marches and on the field of battle, ready to attend to their disease and their accidents.[36]

We assure you that the expectations of today's soldiers do not differ from those described by Dr. Gross. Rapid availability of competent, responsive care for wounds and illness is a major morale factor for today's Army. It is under the kind of battlefield conditions described above that today's combat caregivers will have to meet that expectation.

Moral Dilemmas on the Battlefield

Events on the modern battlefield will not provide an atmosphere conducive to contemplation and thoughtful reflection on ethical theory. There will not be time for careful consideration of ethical principles in making moral decisions and choosing moral actions. Moral dilemmas will abound during periods of intense battle. Conflicts between competing theories of medical ethics will arise and right choices will be made only if caregivers have been thoroughly schooled in the laws of war and intensively trained in a military medical ethic which has been developed by consensus, approved by proper authority, and which should be applicable during peacetime practice as well. Caregivers must not be burdened with rules of conduct which differ in war and peace. Brigadier General Thomas Whelan has said combat surgeons need good hands, a stout heart, and not too much philosophy."[37]

The approach to establishing an operational system of military medical ethics which is applicable during war and peace must depend on several factors. The ideal of having a universally accepted set of moral values based on absolute moral principles that satisfy all requirements for a single ethical theory is unachievable. It is a fact of life that moral dilemmas occur. Our

[34]Carl Von Clausewitz, *On War*. Michael Howard and Peter Paret, eds., (Princeton, NJ: Princeton University Press, 1976), 119.

[35]Ibid., 119.

[36]Samuel David Gross, *A Manual of Military Surgery*, 1861, (Reprinted San Francisco: Norman Publishing, 1988), 18.

[37]Thomas J. Whelan, Jr., *Emergency War Surgery*. Prologue (Washington, DC: U.S. Government Printing Office, 1988), VIII.

best hope is that the greatest good for the greatest number can be achieved by adherence to a system of moral and ethical principles established by consensus. In pursuit of this consensus, several factors must be considered. Beauchamp and Childress have presented a diagrammatic view of ethical systems as a vertical hierarchy."[38] We prefer to think of a moral and ethical system as a pyramidal hierarchy which consists of a relatively large number of individual moral choices and actions which are derived from a smaller number of moral rules. These are based upon a yet smaller number of generally accepted moral principles which satisfy the requirements of a relatively homogeneous ethical theory. Moral dilemmas can then be kept to a minimum and one may more easily discern which moral choices and behaviors are acceptable. The pluralistic nature of our society further confounds our efforts to achieve consensus and renders difficult the best efforts of modern medical ethicists.

Applying Engelhardt's definition of community and society may simplify the task of deriving a moral and ethical consensus for a military medical ethic. He defines a society as a group of individuals who do not share a common view of the good but pursue a number of important goals together."[39] This is consistent with the pluralistic nature of our society. Ours is a citizen Army, its membership derived from society at large, and there is probably no segment of society that is not represented in the military services. Engelhardt defines a community as a voluntary association of individuals through a common concrete view of the good.[40] In many respects, the military is a community isolated form the society at large, a community in which values, of necessity, become relatively homogeneous. It is in this value context that we believe a system of military medical ethics can be developed, based upon ethical theories that apply to society at large. This will allow health care providers to make rational, morally defensible decisions under peacetime conditions and the stresses of modern warfare.

Ethical constructs for military medicine must be derived from the biomedical ethics of our society. A relatively simple and generally accepted system of medical ethics existed from Hippocrates until the middle of the 20th century. With the rapid development of medical technology, we can now do something about almost everything. This has considerably complicated at least the actions which form the base of the pyramidal hierarchy described above. There is a need today for more moral decisions leading to more moral actions complicated by more moral dilemmas than ever before.

Models for Ethical Decision Making

In the the interest of brevity and simplicity, we will not present an indepth discussion of deontological and teleological or utilitarian ethical theories. Detailed reviews appear in a number of publications.[41]

[38]Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics* (New York: Oxford University Press, 1989), 35.

[39]H. Tristram Engelhardt, Jr., *The Foundations of Bioethics* (New York: Oxford University Press, 1986), 50.

[40]Ibid., 49.

[41]Ibid., 95, Beauchamp and Childress, 25-44, Mappes and Zembaty, 1-43.

Suffice it to say, development of a system of military medical ethics must be based on understanding and contemporary application of those principles. Briefly, the deontological view, epitomized in Emanual Kant's categorical imperative, holds that one has a duty or obligation to choose rational, morally defensible actions regardless of the consequences."[42] If the action or decision is correct, it is the more acceptable and proper course even if the end result is not the preferable one. In actual practice today, the deontological position is rarely subscribed to. The utilitarian view, which is more broadly applied in contemporary moral decision making holds that, within limits, actions which do not fully satisfy a moral standard may be acceptable if the outcome is good or is the most desirable.[43] The difficulty comes in establishing the limits beyond which the means to an end unjustifiably transgresses the moral standard.

The primary moral principles of medical ethics are autonomy (patient's wishes), nonmaleficence (doing no harm), beneficence (taking action to help), and justice (providing what one deserves or needs).[44] Within the principle of justice are the utilitarian (maximize public utility), libertarian (liberty of choice), and egalatarian (equal access) schools of thought.[45] Of particular concern is the issue of distributive justice and its implications of one's right to medical care.[46] Autonomy, the right of self-determination, may come into conflict with beneficence or the paternalistic approach the physician or other caregiver may take in deciding what action is in a patient's best interest.[47] Also, the statutory responsibility commanders have for the health and welfare of their personnel fosters an attitude of paternalism in the military environment. As a basis for a system of military medical ethics, each of these principles remain valid in the context of peace and war; they are interdependent and not independent, and pursuing one may create conflict with another.

The following examples, some actual, some hypothetical, will serve to further illustrate the purpose of this presentation. The Medical Department exists to preserve the fighting strength of the Army. Communicable diseases, if allowed to become epidemic, may render large numbers of soldiers ineffective. A simplistic and perhaps minor example of the moral dilemmas encountered in military medicine is seen in the practice of immunizing against a number of communicable diseases. The principle of beneficence is served. It is in the individual soldier's best interest to prevent his illness. It is in the Army's best interest to prevent an epidemic. Nevertheless, immunization is not optional, so the recipient's autonomy is infringed upon. The same may be said of the prophylactic administration of gamma globulin or of antimalarial drugs in the tropics.

Some immunizations are attended by a predictable rate of adverse reactions that may cause modest morbidity and occasional mortality. The

[42]Ibid., 17-22.

[43]Ibid., 7-17.

[44]Beauchamp and Childress, Chapters 3-6. These chapters contain excellent, thorough discussion of the principles listed.

[45]Ibid., 265, 266, 268.

[46]Ibid., 243-244.

[47]Mappes and Zembaty, 33.

interest of the military are served by disease prevented. However, if nonmaleficence is to avoid or prevent harm, that principle is poorly served for the rare individual who experiences an adverse reaction. Also, he is not asked whether he wants the immunization; thus he is denied his autonomy. A parallel certainly exists in civilian public health since, in many communities, children cannot attend school without proof of immunization.

Perhaps a more challenging problem is confronted when one faces the need to transfuse blood as a lifesaving procedure for a Jehovah's Witness soldier who could survive an otherwise mortal wound and return to battle. Beneficence is served but he is denied autonomy in this decision. One is tempted to defend transfusing this soldier on the basis that he has, in a sense, willingly accepted limits on his autonomy by voluntarily becoming a member of the military community. As defined by Engelhardt, this is a community the soldier, at least tacitly, subscribed to for a common good.[48] This would assume, of course, that he is a volunteer and not a conscript.

The most serous threat to autonomy is the necessity to triage casualties on the battlefield. Battlefield experience reveals that triage is rarely practiced as prescribed. It is not unusual to see the dead and dying thrown aboard evacuation helicopters to the possible peril of all, crew and potential survivors alike, because medics could not bring themselves to relegate anyone to the expectant category. While triage may serve beneficence, perhaps nonmaleficence, and preserve the fighting strength, it certainly denies autonomy.

Furthermore, it raises the question of distributive justice.[49] Battlefield triage becomes necessary only because not all casualties can be given sufficient care. The individual charged with responsibility for triage first faces the ethical dilemma of deciding in which cases care would be futile. Medical futility determinations are at best educated estimates of probability.[50] Those relegated to the expectant category exercise no autonomy in that decision. The most severely wounded or those with catastrophic neurological injury lack the competence to exercise autonomy. Of the remainder, it would seem that each would be treated according to his need. Suppose, however, that caregivers are simultaneously confronted with casualties of their own forces, allies, noncombatant civilians, and enemy prisoners of war. Moral and ethical principles of just war and the generally prescribed laws of war dictate equal treatment of each of these groups. Will one pursue the course of utilitarian justice in caring for each person according to status or of the value of the individual to the community or society? Commanders and caregivers, both potentially culpable for breach of the laws of war, must be adequately prepared to make the moral decisions demanded in these circumstances.

Colonel (Ret) James G. Van Straten, Dean of the School of Allied Health Sciences, The University of Texas Health Science Center at San Antonio, delivered the keynote address at the conference "Medical Ethics and

[48]Engelhardt, 49.

[49]Benedict M. Ashley and Kevin D. O'Rourke, *Health Care Ethics* (St. Louis, Mo: The Catholic Health Association of the United States, 1982), 239.

[50]Lawrence Scheiderman, Jr., et al. Medical Futility: Its Meaning and Ethical Implications. *Ann of Intern Med* 112:949-954, 1990. John D., Lantos, et al. The Illusion of Futility in Clinical Practice. *Am J Med* 87:81-84, 1989.

the Health Care Provider Team on the Battlefield," held in San Antonio, Texas in May 1990. The conference was held under the auspices of the Chief of Chaplains, United States Army and The Surgeon General of the U.S. Army. Colonel Van Straten included in his address vignettes of some experiences he had during combat in Vietnam. With his permission, two of those will be presented to underscore problems facing caregivers on the battlefield.

On several occasions during the Vietnam War, it became necessary to relocate the citizens of hamlets and villages in or near the demilitarized zone between North and South Vietnam. Viet Cong troops had used the villages as safe havens and the inhabitants as shields against retaliatory strikes by U.S. and South Vietnamese forces, clearly in violation of the Just War Theory and laws of war. The stress of the surrounding conflagration and an enforced move caused a number of women with infants to cease lactating. Despite requests American military medical advisors and Vietnamese military medical authorities, an alternative source of nourishment was not provided and several infants died. The rationale for this decision was that the mothers would not accept formula feeding because of cultural factors or lack of familiarity with its use. No malice was intended but the fact remains that sound advice was ignored by military advisors because of their own cultural bias. In subsequent moves, infant formula was provided and proved to be satisfactory. Clearly, the principles of justice and non-maleficence were not served in this case.

In another incident, a seriously wounded Vietnamese soldier was delivered by medical evacuation helicopter to a U.S. hospital along with a number of Americans with varying severity of wounds. Despite Colonel Van Straten's attempt to obtain appropriate lifesaving care for the wounded Vietnamese, the hospital staff continued to care for all, even the most minimally wounded of the American casualties, before turning their attention to the Vietnamese soldier, and then only because of Colonel Van Straten's insistence. Although the American hospital commander subsequently disclosed that he had an unwritten agreement with the commander of a nearby Vietnamese military hospital that each facility would care for his own casualties, the principle of justice and the generally prescribed laws of war were not served in this case.

Conclusion

This paper does not address such issues as the sordid record of medical experimentation during World War II conducted by such vicious war criminals as the German Dr. Joseph Mengele, or of Japanese physicians who secretly killed over 3,000 Chinese prisoners in medical research.[51] We have not addressed the questionable behavior of the physician who, as a prisoner of war, was pressed into caring for Japanese soldiers in Burma and availed himself of opportunities while treating his captors to infect his patients with amoeba and other organisms. The ethical and moral implications of medial personnel who have witnessed but failed to report torture, mistreatment, and

[51]Van Straten

murder of prisoners during interrogations are not discussed. However, it is essential that these concerns be included in a codified military medical ethic.

Dr. Swann's article has raised the issue of euthanasia on the battlefield. This is a problem which must be dealt with. Dr. Swann's depiction of the modern battlefield on which health care resources may be overwhelmed by great numbers of casualties is realistic. Yet, consideration of euthanasia under such circumstances cannot be divorced from the moral standards which apply to the society from which our military forces are drawn. If the morale, confidence, and loyalty of soldiers are enhanced, as Dr. Samuel Gross said,[52] by knowing they will receive medical care, what devastation will be wrought upon the unit whose members fear death at the hands of those to whom they look for care and comfort?

This dissertation has not attempted to answer all of the myriad questions surrounding the issues of military medical ethics in peace and war. Rather it has presented a broad view that the moral and ethical basis of just war and biomedical ethics for society at large must provide the foundations for development of a military medical ethical system that is rational and justifiable. Furthermore, caregivers must not go into battle without a reasonable understanding of the expectations placed upon them for sound, ethically and morally supportable decisions.

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[52]Gross, 18.

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Battlefield Triage

Robert H. Mosebar

Combat casualty triage evokes images of mass casualties overwhelming available medical resources, deliberately laying aside the more seriously injured to die. The connotation of triage in the military environment has, since the advent of nuclear weapons, been that of huge numbers of casualties overwhelming the medical capability. Mass casualty exercises became popular in the late 1950's and early 1960's, first in the military and subsequently practiced by civilian hospitals in the United States. Major transportation accidents and destructive severe weather disturbances in population centers were included, in addition to a nuclear exchange with the USSR as generators of mass casualties.

Mass casualties are triaged into four group: immediate, delayed, expectant and minimal. Immediate casualties have injuries that are life threatening and require prompt action. Examples are an obstructed airway or continuing hemorrhage, especially in an extremity. Both are life threatening, but can be managed by relatively simple and short medical procedures as contrasted to those injuries that require several hours in an operating room. The prognosis is usually relatively good. The delayed group consists of casualties who do not require immediate attention: they will remain relatively stable for several hours without time-consuming procedures. Example of injuries in this group are closed fractures adequately splinted, soft tissue wounds without significant hemorrhage and other wounds that will not cause significant physiological deterioration during the delay prior to treatment. Their chance of survival is also relatively good. The expectant group has been the focus of much discussion and concern. These are casualties that require extensive time and immense resources for their treatment. Their survival is questionable; they have a high probability of dying. Examples are the open penetrating head wound with extensive brain involvement, the severe chest wound with hemorrhage, the extensive full thickness burn, especially with inhalation of flame. The casualties require prolonged operating room

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time, staff and medical supplies. Extensive resources are not devoted to this group until immediate and delayed casualties have received full treatment.

In modeling studies these three groups each comprise about 20% of the casualties. The fourth and final group are the minimal casualties, comprising about 40% of the total. They are for the most part the walking wounded, although some may have lower extremity injuries which preclude walking. Examples are minor soft tissue wounds, small burns, and closed fractures of small bones. The group would in many cases return to duty relatively soon, require minimal treatment and resources. The combat stress (psychological) casualty would be included in this group. Some members of this group may be used as a labor pool; litter bearers are always in short supply.

Mass casualty triage does not exist in reality. There is no evidence that mass casualty triage has been employed on the battlefield. Triage, simply defined, is the process of sorting all patients in the combat environment. Triage is an ongoing, continual process in the case of wounded and injured soldiers. The word is derived from the French and means to sort. Triage determines priority for treatment, and in actuality usually places the more severely wounded in the earlier treatment category. Mass casualty triage has inappropriately permeated our doctrinal literature.

During the first day of Operation Just Cause (December 1989) only two casualties were treated expectantly of more than 150 casualties. Obviously these were patients who had no chance of survival. From January to June 1968 during the Tet Offensive in South Vietnam, the Da Nang Naval Hospital treated 2021 consecutive U.S. Marines wounded. Only 17 were considered non-survivable (less than 1%), 12 of the 17 were severe head and brain injuries. It is usual in combat to medically observe penetrating unconscious head wounds with continuing progressive deterioration in a preoperative area to determine whether the patient will stabilize and then undergo surgery or continue to deteriorate and die. This is not expectant treatment; rather it is using good professional judgement. A 1969 review of all admissions to U.S Army hospitals in the Republic of Vietnam revealed that 600 surgical patients died within 24 hours of admission. Obviously many of these patients were delayed by mass casualty criteria but the practice was to treat the gravest injured first, probably requiring extensive operating time. This matches the civilian practice and is the result of years of physician training.

Another system of battlefield triage, agreed to by our international military allies and commonly used in civilian practice uses three priorities, simply designated 1, 2, and 3. Priority 1 designates a casualty requiring urgent medical treatment, usually within 6 hours or less, without regard to available resources. This casualty has the gravest injury and has the lessor chance of survival of the three groups. Group 2 casualties can have treatment delayed up to 12 hours without significant deterioration. Group 3 comprises those who can be delayed beyond 12 hours without jeopardizing the casualty. Our standard operating procedure through several wars has been to use this triage system. Earlier it was noted that triage was continual and dynamic which requires a frequent review of Group 2 and 3 to be certain that their psychological parameter has not changed, and if there is change to determine if priority should be changed. In December 1950 the 8055 MASH, a 60-bed

hospital, received some 500 casualty during one night as a result of the surprise entry of the Peoples Republic of China, in force, into the Korean War. Mass casualty triage was not utilized. The patients were repeatedly triaged, and all priority 1 patients were operated during the night and into the next day. There were no deaths. Within 24 hours all patients had been evacuated.

During the darkest days of the Pusan Perimeter defense in August and September 1950 all casualties generated during the day in two divisions were loaded onto a Korean train for a five hour trip to the two Army hospitals in Pusan. The trains were dark and the litters were stacked across the wooden backs of the coach seats. Many of these casualties were seriously wounded, with blood dripping from their wounds onto the casualties on the floor. No one was shouting out, no one asking for care out of turn. The hushed moans were heard throughout the Korean train coach cars. The patients were unloaded by flashlight, treated by priority upon arrival at the hospitals, the gravest injuries first. Some of the casualties had died during the trip.

The triage officer is usually the most experienced surgeon. However, in the chemical warfare environment, doctrine suggests that a knowledgeable senior medical noncommissioned triage the casualties as they arrive at the medical treatment facility. Triage is a necessary function, and is used during forward evacuation of the wounded. The priorities employed for helicopter evacuation are *urgent* (most severely wounded), *priority* (evacuation can be delayed) and *routine*, not unlike triage priorities 1, 2, and 3.

Triage is dynamic and continuous since a patient's condition is subject to change. Triage varies with the situation and is necessary to bring organization out of the chaos associated with large numbers of patients. Every soldier is entitled to medical treatment when wounded and expects medical care. Triage is doing the most good for the greatest number.

There have been occasions, especially during the Korean War, when wounded were left behind as the U.S. Army retreated. Medical personnel remained with the casualties, along with medical supplies.

The combat medic does not triage; he has no time to decide who must be rescued first. His role is to collect casualties in a safe location, treat them, and prepare them for evacuation.

Mass casualty doctrine was designed for nuclear war, but unfortunately many mock casualty exercises use mass casualty scenarios. Placing injured in expectant categories is abhorrent to most physicians unless there is no chance of survival. A surgical backlog does not justify the triaging into expectant category without additional justification. The U.S. Army has overemphasized the use of mass casualty triage and underemphasized the priority 1, 2, and 3 system.

Euthanasia on the Battlefield

Steven W. Swann

Editor's note: This somewhat controversial article was selected to help indicate the wide range of understanding within the medical community regarding euthanasia. It is intended to contrast to other positions, not to express preference or policy.

Introduction

Battlefield euthanasia has been a topic in military medicine since antiquity. The modern battlefield, however, will be one of intense destruction and greater lethality than previously known. Because the number of casualties will overwhelm any medical support system, the issues related to euthanasia in the combat setting will need to be addressed. In this paper I have reviewed the historical basis for battlefield euthanasia and outlined the ethical constructs by which physicians can formulate their decisions. The morality of euthanasia as a treatment option for the mortally wounded soldier is controversial, but, as discussed in this paper, I believe its application can be supported in certain instances.

Scenario

Consider the following scenario: Three weeks ago U.S. Naval forces in the Mediterranean launched air and sea attacks against military installations in Libya in response to increased terrorist activities known to originate from Muammar Quaddafi's regime. This was followed by the invasion of the 2nd Marine Division near Tripoli. This military action was applauded by Israel but condemned by most NATO allies and, as expected, by the Arab world and communist block nations. U.S. forces suffered few losses and easily secured the country with complete destruction of the Libyan Army. In retali-

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ation, certain Arab countries attacked U.S. forces in Libya and simultaneously invaded Israel. U.S. Naval forces suffered minimal losses from the Soviet-supplied navies and air forces of these nations, and although the marines have sustained moderate casualties, they still control the battlefield.

One week following the opening of hostilities in North Africa, Warsaw Pact nations began unscheduled, large-scale "Training Exercises" near the East-West German border. Six days ago these units crossed into the Federal Republic of Germany and attacked NATO units to force a U.S. withdrawal from Libya. The U.S. refused, and combat in both regions has continued to escalate.

As a surgeon in a clearing station in direct support of the 11th Armored Cavalry Regiment defending the Fulda gap, I have seen many casualties of all types. I knew that modern warfare would create great numbers of wounded and cause massives destruction, but I had no idea it would be this terrible. Our unit has taken 65% losses. Despite heroic actions, we continue to be forced back 30 to 60 km each day, but short of the Soviet doctrinal 100 km daily advance. The 85th Guards Motorized Rifle Division oppose us, and their lines are 8 km away. They are expected to be at this location in 45 minutes. Intelligence reports that all severely wounded prisoners are being executed, for the Russians do not want to slow their attack to deal with the problem of caring for or transporting them.

In my clearing station I have no capability to hold patients or transport them with me, I can only triage, initially resuscitate, and then evacuate with higher command assets. At the present time we have 32 wounded. 17 of which are categorized as expectant. They include a German civilian with abdominal evisceration who is pleading to die, two unresponsive soldiers with extensive head wounds, two soldiers with 80-90% total body burns from chemical contamination, eight soldiers who have received a dosimeter-documented 825 rads after unknowingly crossing a nuclear-contaminated area and who continue to vomit and pass diarrheal stools, and a four-man tank crew all of whom received between 60 and 90% body surface area, full thickness burns after the fuel cell of their M60A3 exploded when hit with a Sagger anti-tank missile. The screams of the wounded could easily expose our position to the attacking Soviet forces or to the Russian commando units known to be operating behind our lines.

The 3rd Armored Division, whom we are screening, will take 3 hours to get land evacuation to me. Air evacuation is not available since the Soviets have air superiority, and besides, we have already lost 80% of our helicopter assets. I lost 40% of my men and equipment, including another physician, a pediatrician, when our convoy was strafed by MiG-27's 2 days ago. I have not been resupplied in 2 days, and I am running short of everything, especially morphine, bandages, and IV fluids. I have just received orders to displace in 15 minutes and be ready to accept new causalities from the intensified fighting in 30 more.

Oh, Lord, there is nothing medically I can do to extend the lives of these brave men. They are all doomed to die and suffer immeasurably until they do so. Need I kill these men? Should I take this merciful action so as not to postpone the unalterable?

Discussion

As the scenario suggests, monumental events often create monumental issues. Throughout history medicine and war have made major and substantial impacts on the life of man. In today's world the technical achievements of both can paradoxically keep a patient biologically alive for an almost indefinite period and, yet, have the capacity to destroy all life on Earth. The capability to wage war with current technology makes the battlefield more lethal than ever before. Clearly, new technology can produce more casualties in a shorter period of time than previously known, and those numbers can completely overwhelm any medical support system. If that were not enough, the modern battlefield will also be one of great maneuverability at rapid speeds, thus creating the situation where medical logistics and support may be outstripped by the vicissitudes of war. This will make time a critical factor in all aspects of combat and combat support. Since modern war technology is an actuality and its use will produce many dead and wounded, the question of euthanasia will arise and must be answered. This will be especially true when only limited medical resources are available.

Of what exactly are we speaking? Euthanasia is the deliberate putting to death in a merciful, painless, and swift manner an individual suffering from an agonizing and incurable disease or injury. The outcome must not cause increased suffering, and there must be no other relevant circumstances apart from the desire to benefit the patient.[1] Many modifiers have been used to define different types of euthanasia; e.g., active versus passive, positive versus negative, willing versus nonwilling, and voluntary versus involuntary versus nonvoluntary. In this discussion, active euthanasia, that in which direct measures are taken to terminate one's life, and passive euthanasia, that in which no actions are taken and the patient is allowed to die, will be used. A further distinction of medical and tactical euthanasia can also be made. The former refers to euthanasia initiated for medical reasons by a physician as will be discussed in this paper. Tactical euthanasia, be it passive or active, is a decision of the commander incorporating factors not directly related to the condition of the patient. For example, a soldier with lesser wounds, but possessing military information of great significance, whose capture could result in greater losses or defeat may need to be killed. Tactical euthanasia may conflict with medical decisions and therefore is decided upon and implemented by the commander. This is a completely separate issue, not further considered in this paper. The end result of all forms of euthanasia is the same, and that is the death of the patient. The difference is in the methodology and not in the intent or responsibility. To allow a patient to die is to intentionally resist from saving his life when able to do so. Therefore, one's intention is for the patient to die. If it were not, then an attempt to preserve life would be made. Therefore, the intention is the same as one who utilizes euthanasia. Only the methods are different: the outcome is the same. Also, it does not matter whether a physician's actions or inactions result in

[1]Suckiel EA: *Death and Benefit in the Permanently Unconscious Patient: a Justification of Euthanasia.* J Med Philos 3:38-52. 1978

the patient's death. His responsibility for the patient's death is ultimately the same whether he actually participates or actively refrains from treating. Therefore, the subtlety between killing the wounded on the battlefield and allowing them to die is ethically insignificant.[2]

The argument for or against euthanasia has raged for years and recently become increasingly heated with the development of new medical technologies. These arguments have been made using various ethical approaches and have primarily included considerations of autonomy, sanctity of life, and costs and benefits to the patient, the family, and society. The civilian scenario usually occurs in a hospital setting with all current medical science available, with adequate time to consider the case, and with consultants near by to offer advice and support. Battlefield considerations for or against euthanasia also include these factors, but due to time constraints unique to combat, mass casualty situations may require life-determining triage to be made in very short periods; and those decisions, however difficult, will most likely rest on the shoulders of a young doctor, alone, in the midst of intense destruction. Therefore, the question that confronts the physician is: is it ethically correct for a physician to use euthanasia as a method of treatment for severely wounded in combat? I support the opinion that in war, euthanasia is a justifiable method of treatment available to the physician. Nonetheless, to make this statement begs the question of how one can morally support such a position.

On the modern battlefield physicians will be faced with wounded of all types, of many nationalities, and in greater numbers than previously known. They can expect to treat both male and female American soldiers, allied soldiers, displaced civilians of all ages, and prisoners of war. Gunshot and fragment wounds are to be expected, but with the lethal and diverse arsenals available to potential combatants, one must expect more severe and incapacitating wounds, such as multiple trauma, multiple amputations, severe burns, chemical casualties (especially from blister and nerve agents), as well as burns, blast injuries, and lethal contamination from nuclear weapons. Many of the wounded being seen with such injuries will not be attended because treatment will not be technically or physically available. The medical support system will be overcome with wounded, will not have enough resources, will not have enough time, and will not have transportation ready to bring the wounded to a treatment facility. In such an environment, how ought a physician to act in conscience and in regard to his/her patients?

A system has already been devised to guide physician decisions concerning treatment in disaster medicine scenarios. This is the concept of triage. It is based upon the principle of accomplishing the greatest good for the greatest number of wounded and injured at a particular time.[3] It is an extremely variable concept, changing in its application as the situation, available resources, and time constraints change. Utilizing the principles of triage, a

[2]United States Department of Defense: *Emergency War Surgery*. Washington, DC. United States Government Printing Office, 1975, p 153

[3]Dyck A: *Beneficent Euthanasia and Benemortasia: Alternative Views of Mercy, in Death, Dying, and Euthanasia*, Edited by Horan D. Mall D. Frederick, MD. University Publications of America, Inc. 1980, pp. 348-461

physician screens patients, determines their priority for treatment, and then treats based upon this initial assessment. The initial evaluation takes into account type and severity of injury, time required for treatment, and resources required. A patient is continually reassessed and their priority for treatment may change. Decisions concerning life and death are first made at the initial assessment and are repeated throughout the patient's course. If a patient's injuries place him into a category in which he is expected to die, then treatment is usually withheld, and the patient is comforted until he expires or until time and resources become available to treat his highly medically demanding injuries. The decision to allow the patient to die is necessarily made, and it is here where euthanasia could be employed.

There is a conceivable civilian correlate to the above presented scenario. Disasters, either natural such as earthquakes, floods, and storms, or manmade such as nuclear reactor malfunctions, chemical plant accidents, and terrorists attacks, could produce the multitude and types of injuries in a nonmilitary population as can be expected in war. Resources elsewhere in a community may be available, but time to mobilize them may not be available before those destined to die have suffered. Thus, like their military counterparts, civilian doctors potentially could find themselves in similar stressing situations demanding similar life and death decisions to be made regarding triage and euthanasia.

Historically, military leaders and physicians have taken both sides of the issue. The first known request for euthanasia on the battlefield was recorded 3,000 years ago in the First book of Samuel, Chapter 31, in which King Saul requested his armor bearer to slay him after he was severely wounded in battle by Philistine archers and before capture by the enemy. His armor bearer refused, so Saul took his sword, fell upon it, and died.[4] Greeks and Romans permitted euthanasia or suicide as an alternative to a lingering and painful death.[5] At the mountain top fortress of Masada in 70 AD, a large number of Hebrew soldiers and their families chose euthanasia and suicide in mass to escape capture and conversion or expected, painful death from Roman Legions.[6]

Ambroise Paré, the famous 16th century surgeon, describes an event that occurred early in his career during the attack on Turin, Italy, in 1537:

> Being in the city, I entered a stable, thinking to lodge my horse, where I found four dead soldiers and two others who were not yet dead propped against the wall, their faces wholly disfigured, and they neither saw, nor heard, nor spoke, and their clothes yet flamed with the gunpowder which had burnt them. Beholding them with pity, there came an old soldier who asked me if there was any means of curing them. I told him no. At once he approached them and cut their throats gently and without anger. Seeing the great cruelty, I said to him that he was an evil man. He answered me that he prayed God that when he should be in such

[4]I Samuel 31. *The Holy Bible*, (King James Version.) Cleveland, OH, World Publishing Company, p 228

[5]Rachels J: *The Sanctity of Life, in Biomedical Ethics Review*, Edited by Humber J, Almeda R. Clifton, NJ, Humana Press, 1983, pp 29-42.

[6]Schiff Z: *A History of the Israeli Army* (1970-1974). San Francisco, Straight Arrow Books, 1974, p 24.

a case, he might find someone who would do the same for him, to the end that he might not languish miserably.[7]

During Napoleon's retreat from Moscow in the winter of 1812, he proposed to his physician, Desgenettes, to give a fatal dose of drugs to several plague-stricken, mortally ill soldiers. The soldiers were unable to march and were likely to fall into Russian hands. Dr. Desgenette flatly refused, believing it was the obligation of the physician to cure and not to kill.[8]

A contradictory event occurred in the spring of 1944 when elements of the 111th Indian Infantry Brigade were engaged with Japanese forces in Burma. After 17 days of constant fighting, the British units retired following their defeat. The infantry carried their wounded with them as they marched. Early in the retreat, Lieutenant Colonel John Masters, the Brigade Commander, was faced with 29 wounded deemed to be terminal by the unit's doctor. These wounded suffered from extensive head wounds and multiple amputations, and one soldier in particular had lost the lower half of his body. The unit surgeon reported that these 19 had no chance to survive, but another 30 could be saved if they could be carried by those litter bearers carrying the severely wounded. Lieutenant Colonel Masters decided to save the 30 that had a chance of survival, and at his and his surgeon's mutual reluctance, had the severely wounded soldiers killed by gunfire from his own troops so as not to allow them to fall into the hands of the Japanese.[9]

These are objective cases. They do not form the rational construct for a theory of euthanasia under combat situations. Rather, the justification to use euthanasia may be approached through many ethical forms. The Hippocratic Oath specifically states.

> The regimen I adopt shall be for the benefit of the patients according to my ability and judgment, and not for their hurt or for any wrong. I will give no deadly drug to any, though it be asked of me, nor will I counsel such, and especially I will not aid a woman to procure abortion.[10]

This oldest and most common medical oath dictates how a physician should view the subject of euthanasia. At first reading, it appears to state that euthanasia is completely prohibited to physicians. If, however, one interprets the oath such that the duty of doctors is to preserve life and relieve suffering, then these dual obligations may be potentially contradictory in that if one increases suffering by extending life, then, I believe, one has elevated one of these equal values over another. If one can rightfully argue that extending life by any means can be of greater moral value, then one can argue in return that relieving suffering by any means can be of greater value than the pres-

[7]Gordon B: *Medieval and Renaissance Medicine*. New York, Philosophical Library, Inc. 1959, p 674

[8]Wilson R: *A Medico-Literary Conserie Euthanasia*. Practitioner 56:131-135, 1896. Reprinted in Risner SJ: "The dilemma of euthanasia in modern medical history: the English and American experience," in *The Dilemma of Euthanasia*. New York, Anchor Press. 1975, pp 27-41

[9]Masters J: *The Road Past Mandalay*. New York. Harper and Brothers 1961. pp 253-254

[10]Lyons A. Petrucelli RJ: *Medicine, An Illustrated History*. New York, Henry N. Abrams, Inc. 1978. p 214

ervation of life. If so, then the taking of life to relieve suffering is morally correct.

Although there is no clear consensus among different religions about the legitimacy of euthanasia, different philosophical models can approach this quandary and give more substance to the discussion. The principle of autonomy directs that the patients values and beliefs should guide the doctor's treatment. By strictly using this model, if a competent soldier wounded on the battlefield requested to die, the physician would be obligated to comply. He would also be obligated to give full available treatment if requested. Under this model the patient's self-determination takes precedence over the values of medicine. However, when multiple casualties are present, whose autonomy takes precedence? In the acute care scenario, the autonomy model would not be practical, for everyone's autonomy cannot be fulfilled. In the individual case, the autonomy model may support or refute active euthanasia depending on the desires of the patient. If the patient were incompetent, however, others would need to speak in behalf of the patient to report the patient's previously expressed views and to present their opinions. In combat it may well be impractical to pull members from the patient's military unit to do so, for family members would most likely not be available. In the chronic care situation, the autonomy model may very well take precedence, but perhaps not on the battlefield.

The principle of beneficence implies that physicians know what is in the best interest of the patient and will treat the patient regardless of the patient's wishes. This may be in direct conflict with the model of autonomy. In the acute care/combat situation, this model would allow for active euthanasia. In combat a physician's primary obligation to his patients is to relieve suffering and pain. He should prolong life if possible, but there will be times when he can only give comfort during the dying process. This is as important a physician function as is saving lives or postponing death. In war there will be some soldiers so severely wounded they will suffer and die despite medical care given. I am not advocating not to treat these wounded. They have made an extraordinary sacrifice for their society and deserve care. But, again, a physician must realize his obligation to relieve suffering and pain may be of greater moral value than that of attempting to keep a moribund patient alive. He will need to shift his efforts from preserving life to comforting the dying. Death may be the only end to the suffering of the "pre-dead" patient.

Therefore, it is believed that death is not always bad, and at times may even be in the patient's best interest. Since death may be in the best interest of the patient, in some situations it may well be that the most beneficial action a physician can take is to terminate the patient's life. If terminating his life most respects the patient's interest, it is unfounded to say it is morally wrong. Therefore, if dying is not always bad, killing may not always be wrong.[11] With dying soldiers in combat when care is not available, it may even be obligated. If time and facilities are available, an attempt to save the patient should be made. If, however, this too would prove to be futile, active eutha-

[11]Suckiel EK: in *Death, Dying, and Euthanasia*. Edited by Horan D. Mall D. Frederick. MD, University Publications of America, Inc, 1980

nasia would still be justified. In the combat scenario, the beneficence model would necessarily be used by physicians. If a physician felt that death was in the best interest, then the decision to use euthanasia would be morally supported.

The utilitarian principle would also support active euthanasia in war. This view supports the philosophy of the greatest good and greatest happiness for the greater number. By eliminating suffering and pain, the military unit would be more effective and its collective happiness would be maximized. How would this be applied? Consider, for example, that the current U.S. Army policy is against euthanasia. Wounded who cannot be evacuated are to be left alive to be captured. Selected medical personnel or, if required, a complete medical unit will remain with the wounded until capture. The corpsman or doctor would then be considered "detained" personnel and released when their medical duties have been fulfilled. This was a standard procedure in North Africa in World War II. These medical personnel, however, may be relegated to the same fate as the captured wounded. In a fast moving war with many casualties, a unit could potentially run out of available medics in meeting this need. Keeping medical units intact and personnel attached would ensure the maximal effectiveness of the higher unit's medical support. More wounded could be treated and returned to duty to improve the unit's ability to wage war, and those who are more seriously wounded, if not terminal, could be treated. To leave medical personnel or units behind could result in future personnel losses from untreated, but treatable, wounds due to the lack of qualified care givers. Predictions suggest that in a major conflict, the U.S. Army will have an insufficient number of physicians to treat the wounded at the onset.[12] In a multi-theater, conventional war, one without the use of chemical or nuclear weapons, there are not enough doctors to care for the expected high number of casualties promptly.[13] This leaves an overwhelming volume of patients needing to be dealt with. How ought these significant number of untreatable patients be treated? Euthanasia would be quick and painless, thus humane, and would allow more time for those wounded who can benefit from treatment. This would increase strength by directly replacing losses with trained personnel, the overall injury and suffering would be decreased, and the unit would be able to continue its mission and protect the interests of a still larger group, the society it is defending.

What would be the consequences from the death of the wounded soldier? The only consequence to the soldier would be his death in which he would no longer suffer from his injuries nor face possible torture or execution by an unknown enemy. While it is true a majority of nations have signed the Geneva Convention Act of 1949 which disallows the killing of prisoners of war, violations and atrocities have occurred since its conception, (e.g., My Lai, Republic of Vietnam, 1968,[14]) and it is conceivable they could occur

[12]Comptroller General of the United States: "Will There be Enough Trained Medical Personnel in Case of War? A Report to the Congress." Washington, DC. U.S. Accounting Office, 1981

[13]Mayer W: in "Let MDs recruit MDs for Wartime:" AMA. Am Med News 29 (37):2, 44, October 3 1986

[14]Berens RJ: "Battle Atrocities." *Army*, April 1986, pp 53-56

again. It is also possible that military forces may become involved in a conflict with a nation that has not signed nor follows the directives of the Geneva Convention. This opposing nation would have no obligation to protect the interests of a prisoner of war except through its own societal and ethical standards which may allow actions contrary to the Convention's directions. If the soldiers are captured and not killed, they may eventually die being transported or from lack of medical care by the enemy. It is also imaginable, although unlikely, that the enemy may treat and heal the wounded, make them prisoner, and repatriate them at the end of hostilities. The experience of the German Sixth Army after surrendering to the Russians at Stalingrad in January 1943 would not lend credence to this assumption. Of the 91,000 captives of the original 300,000-man Army, only 5,000 ever returned to Germany.[15]

The one immutable truth under any of these scenarios is that the physician must always face the consequences of his actions. Whatever decision was made, he would have to live with it. To treat the dying would result in less time and resources for other wounded on whom they may better used. On the other hand, to euthanize could result in the doctor's court-martial under the Uniformed Code of Military Justice for murder. Conviction could result in loss of license or medical privileges, incarceration, or even the doctor's own execution. This drastic result is unlikely based upon past history. Yet, as previously explained, not to treat is the same as killing and should be subject to the same as consequences as actively killing.

Not withstanding the impact upon the physician, it is clear that the unit could be affected in many ways. As described above, the efficacy of the unit would improve, but its morale could be seriously and adversely affected, especially if the consensus of the unit was opposed to active euthanasia. How are the troops to react if the unit physician is placed in a position to kill as opposed to keeping the wounded alive? If not viewed as a compassionate act, seeing comrades die at the hands of fellow soldiers may be very demoralizing, resulting in severe psychological and psychosomatic injuries. This could result in rebellion, murders, atrocities, or other immoral actions by these soldiers. With education and explanations in a free forum by both the physician and the unit's chain of command prior to and during combat, the soldier could understand the reasons for active euthanasia in war and most likely support it. Keeping the soldier uninformed would be the cause of possible adverse reactions.

The consequentualist would support euthanasia with the explanation thus far. But, when evaluating the farthest reaching effects, he may rethink his position. The greatest risk in the use of euthanasia is its potential abuse. In the 1930s and 1940s the German government under the leadership of Adolf Hitler abused euthanasia to its fullest extent. Under the original auspices of "valueless life" the Nazis sterilized between 200,000 to 300,000 psychiatric patients, killed an estimated 5,000 malformed infants, and exterminated 80,000 to 100,000 mentally ill. This developed into the "Final Solution" of

[15]Sulzberger CL: *The American Heritage Picture History of World War II.* New York. American Heritage Publishing, 1966, 253

the "Jewish Problem" which resulted in an estimated 6 million deaths.[16] With knowledge of the past, one would believe social constraints would prevent this abuse, but reports of the last 10 years from Cambodia and the Pol Pot regime would show that this was not necessarily true. If euthanasia is used on prisoners of war, it may become increasingly difficult to distinguish it from atrocities as the stresses of combat increased. Unfortunately, the final consequence of a mistake in euthanasia is always fatal.

A fact of life in war is that soldiers die. No matter how well a doctor performs, the immutability of death is an absolute. Through the process of triage, the military physician makes a conscious choice of who will live and who will die based upon the potential survivability of the patient. From a physician's examination, priorities for treatment are determined and followed. A soldier's particular knowledge, rank, or position of leadership may demand difficult decisions in setting priorities of treatment or using euthanasia. A unit commander may require treatment first for him to continue to command, although his wounds are severe.

The primary value supporting medical euthanasia in war is mercy for the injured on the part of the physician. If death is imminent, it is a greater good to be merciful and painlessly end a life than to allow it to exist in never-ending torture. There is great compassion and wisdom in the statement of Joseph Fletcher: "It is harder to morally justify letting someone die a slow and ugly death, dehumanized, than it is to justify helping him to escape such misery."[17] Thus, euthanasia would allow the terminal soldier a dignified death in the company of friends and comrades who with kindness and compassion can help him to make that final transition of life. This would be a more gracious ending to one's life, and one I would readily accept if placed in such a situation. The value of the wounded soldier is not changed. They may be condemned to die, but this condemnation was made when they were wounded. Euthanasia would give dignity to a possibly meaningless death.

A physician, however, *primum non noncere,* first does no harm. It is conceivable that allowing one to suffer by prolonging death causes more harm than the actual death itself. Under the volatile conditions of war described here, it would be cruel indeed for a doctor to allow a patient to linger in misery when the means to end such misery are available. Therefore, euthanasia is not against the values of a physician when death is unalterable.

A physician's obligation in war, as in peace, is to give the most compassionate care available to the patients in his charge. Every attempt should be made to resuscitate and relieve suffering. In war, however, resuscitation may not be indicated depending the severity of the wounds. Whether the patient dies through lack of treatment or is actively killed, the end result is the same. Speeding the inevitable through euthanasia would be a merciful act to relieve the patient's suffering, and in some cases in war, this may be all a physician can do.

[16]Lauter M: "Mercy Killing Without Consent. Historical Comments on a Controversial Issue." Acta Psychiatr Scand 65:134-141, 1982

[17]Fletcher J: *Ethics and Euthanasia in Death, Dying, and Euthanasia*, Edited by Horan D, Mall D. Frederick, MD, University Publications of America, Inc. 1980, p 229-304

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Results of Discussion Group Reaction to the Battlefield Case Study Presented at the Medical Ethics and the Health Care Provider Team on the Battlefield Conference

David M. DeDonato

The following case study was presented to sixteen discussion groups at the Medical Ethics and the Health Care Provider Team on the Battlefield Conference, held 14-18 May 1990, in San Antonio, Texas. Each group numbered no more than sixteen persons and included at least two physicians, four nurses, five chaplains, and various Medical Service Corps officers, senior enlisted AMEDD personnel, and chaplain assistants. Army, Air Force, Navy and Marine Corps active duty and reserve component personnel comprised the 257 conferees in attendance.

Case Study

You are a member of a medical treatment facility deployed in a combat environment in the first week of hostilities. Your facility has received a large number of patients from the units you are supporting. At the present time your patient census is 87%; 53% of those patients are in the "expectant" category. You have patients with abdominal eviscerations, extensive head wounds, and a four-soldier tank crew with 60-90% body surface area, full thickness burns. Air evacuation is not possible because the enemy presently maintains air superiority. Land evacuation from supporting units will take three hours to arrive at your location.

Your unit has suffered the loss of 40% of its personnel and equipment. You have not been resupplied in two days and your supply level of bandages, IV fluids, drugs and medications, particularly morphine, is depleting quickly. Additionally, your unit has just received orders to displace to a new location and be prepared to accept new patients from intensified fighting.

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Given the present situation, your unit cannot evacuate the patients you presently have to another treatment facility. Your unit does not have the equipment or personnel to relocate with your present patient population. Your commander has called a meeting and wants your input to formulate a course of action.
[Excerpted from "Euthanasia on the Battlefield," Captain Steven W. Swann, MC, USA. *Military Medicine*, 152, no. 11 (November 1987), 545-549.]

Each group was asked to respond to the following questions:

1. What is the recommended course of action to the commander?
2. What are the ethical implications that emerge from the case?

The results of the group reports follow.

What is the Recommended Course of Action to the Commander?

1. Leave "expectants" at present location with a minimum amount of health care providers and protectors to care for them. Be honest about the situation with everyone, both patients and care providers. Take all other patients and staff members with bulk of medical supplies to new location. (6 groups)
2. Leave "expectants" with limited number of care providers and supplies for survival. Contact support units to come forward to evacuate soldiers left behind as soon as possible. Moving element will be resupplied enroute or upon arrival at new location. (4 groups)

Variations: a. Relocate as ordered. Leave one or two volunteers behind to provide palliative care. Pick up those left behind in 3 hours. [2 groups]

b. Move as directed. Leave chaplain(s) and health care providers behind with 3 hours worth of supplies. Leave weapons with soldiers in case they have to defend themselves. [1 group (Subgroup: leave one chaplain and no weapons)]

c. Leave the most serious "expectants" behind with some volunteer health care providers but *no supplies*. [1 group]

3. Attempt to appraise combat commander of actual situation and get him to amend orders. Request land navigation for wounded as soon as possible. [1 group]

Variation: Make sure commander knows actual situation. Begin to tear down equipment you are going displace. Leave some tents for "expectants" who will be left behind. Leave patients you can't carry, but *don't commit euthanasia*. Try to return if possible. (If enemy arrives within 45 minutes, stand and defend.) [1 group]

4. *Subgroup Divergences from Group Consensus*

a. Disobey orders. Don't move unit. There is strength in numbers. Continue with business as usual. Wait for something to happen. [2 group]

b. Euthanize "expectants;" displace all others to new location. [1 group]

c. Call headquarters, get orders changed. If you can't, disobey orders and remain in place with entire hospital. [1 group]

d. Leave "expectants" and non-ambulatory patients behind with one chaplain and minimum number of health care providers.

Ethical Considerations That Have Emerged From The Battlefield Case Study

1. **Beneficence:** Doing the greatest good for the greatest number by moving bulk of equipment, personnel, and ambulatory patients. What is best for "expectants"?

a. *Utility*: Risk-benefit analysis of leaving "expectants" behind with limited supplies and health care personnel versus having unit stay in place. Benefits of displacing unit with ambulatory patients and bulk of supplies to prepare for new patients has greatest utility.

b. Do we obey or disobey the order? What are the risks and benefits of not obeying order and remaining in place?

c. Is euthanizaing "expectants" the greatest benefit if we do leave them behind? Benefit to them or to fulfillment of mission? Will enemy honor the Geneva Convention as it pertains to wounded and health care providers?

2. **Nonmaleficence:** Doing no harm to "expectants" by rejecting euthanasia, either by allowing them to die (passive) or hastening their death by employing a lethal means (active).

a. Practicing euthanasia does not meet the moral expectations of our society. U.S. soldiers do not expect to be left behind to die ("we just don't do that").

b. Would a greater harm be done to "expectants" if we left them behind to suffer agonizing death? Possibly at the hands of an non-compassionate enemy?

c. Principles of due care and double effect apply here. The health care provider team has a duty to patients as well as to fulfilling the mission. Leaving "expectants" behind with care providers minimizes doing active harm (euthanasia). Euthanasia would not even be considered an option if the situation didn't call for extraordinary measures. If the mission could be carried out by either remaining in place or the transportation assets were available to evacuate all patients, this would be done.

3. **Autonomy:** Respecting the wishes of patients to be left behind without any further treatment, or evacuating those who do not want to be left behind even if they are "expectants." This would require that the patients be told the truth about the situation.

a. How do we choose the health care providers who will remain behind? Depend on volunteers? Draw lots? Command-directed selection?

b. Who will be the mercy killing agents if euthanasia is the choice?

c. Should we permit "expectants" to expire on their own by removing IVs to hasten the process if that is their choice?

4. **Justice:** Distribution of scarce resources—both personnel and medical supplies. Unit is at 60% strength, supplies are limited, and evacuation assets are not immediately available.

a. How do we determine which health care personnel are mission essential and will be moved with unit to new location? What type of health care personnel do we leave behind—physicians, nurses, corpsmen, chaplains?

b. How do we determine how much and what type of supplies are to be left behind? Do we give emphasis to palliative care to our present patients ("expectants") or to care of future patients who will be at our next location?

c. Will the size of our hospital demand that we leave much of its equipment behind, or do we spend most of the limited time available to dismantling it. How much will this detract from time spent in patient care?

Health Service Support-Futures and the Unit Ministry Team: A Look at the Hospitals

Catherine A. Call
Kenneth M. Ruppar

The operation principle for priorities of religious support in combat operations is threefold: "**Nurture the Living," "Care for Casualties," and, "Honor the Dead."**[1] This principle helps the Unit Ministry Team (UMT) focus religious support on the battlefield. All three priorities are important. Aspects of each priority will be done simultaneously. However, at any given time, the UMT will emphasize one aspect according to the mission of the supported unit. Before engagement, the priority is nurturing the living. Care of the casualties is primary during the actual combat. After the engagement, honoring the dead is essential.

All UMTs will spend some part of their battlefield ministry time with casualties. As this happens, the UMT will interact with members of Army medical units. Some UMTs will interface only at the maneuver battalion level. Others will experience the more extensive care provided by hospital medical personnel. Regardless of where the interface occurs, the UMT can improve its delivery of religious support with an understanding of Health Service Support. This paper focuses on the "Care of Casualties" within the hospital portion of this system.

Familiarity with the changing concept and design of the Army's Health Service Support will enhance the UMT's ability to provide timely and effective religious support to casualties. Today's force structure has seven TOE hospital types. In the future, organizations such as Station Hospitals and Evacuation Hospitals no longer will exist. Names such as Mobile Army

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[1]FM16-1, *Religious Support Doctrine: The Chaplain and Chaplain Assistant.* p. 5-2.

Surgical Hospital (MASH) or Combat Support Hospital (CSH) may sound familiar, but structure and missions will change.

This paper addresses the religious principle of "Care of Casualties" and focuses on a concept of religious support for the future hospital system. It introduces the UMT to current changes in the Army's concept of battlefield hospital support. It identifies hospital missions and suggests religious support emphases to complement those missions. This paper is based on the concept that hospital missions help shape the form of religious support, and the hope that thinking about this will improve the training and future practice of religious support. The goal for the paper is twofold: 1) that the UMT will become familiar with a future concept of religious support tailored to hospital missions, and, 2) that both medical and religious support personnel will have a clearer understanding of how their roles complement one another.
The material follows this general outline:

A. Introduction to Health Service Support-Futures (HSS-F)
B. Hospitalization under HSS-F
C. Religious Support Concept for the Hospitals

A. Introduction: Health Service Support-Futures

The motto of the Academy of Health Sciences U.S. Army, is, **"To Conserve Fighting Strength"**. This motto reflects the focus of the Army Medical Department (AMEDD). The AMEDD wants to return to duty (RTD) as quickly as possible the greatest number of soldiers. Meeting this challenge required changing the system for delivering health service support on the battlefield. In 1982 the AMEDD began a process of modernizing all of its TOE units. Seven years and many changes later, the process produced a revised concept of health service support call **"Health Service Support-Futures"**, or, **"HSS-F"**. After developing the concept, the AMEDD began designing force to deliver the health services. This force is known as **"Medical Force 2000"**, or, **"MF2K"**. Structuring of the TOE units within this force continues. Over the next several years the Army will experience a phased change from current units to MF2K units.

As background to understanding the hospital portion of HSS-F, it is important to be familiar with the medical care available prior to a casualty's entrance into a hospital.

Level One medical support is that which is commonly known as unit level care. This care is provided by medical platoons/sections of combat/combat support battalions. Emphasis is on those actions necessary to resuscitate, stabilize, and allow for evacuation of the patient to the next level of care. Measures frequently include maintaining an airway, stopping bleeding, and preventing shock. An individual or a treatment squad provides care at this level.

In far forward areas in the absence of a physician, three skill levels of personnel provide needed care. They are, **(1) Self-aid/Buddy-aid:** each soldier learns basic skills for first aid to alleviate a life-threatening situation. **(2)**

Combat Lifesaver: a non-medical soldier receives additional training beyond basic first aid. The soldier retains a primary duty but assists the medic in providing medical care when the situation allows. The expectation is to have one such soldier in each squad, team, crew, or similar unit. **(3) The Combat Medic (Aidman):** the first soldier in the health service support system to care for a casualty. This person provides emergency medical treatment (EMT) based on formal medical MOS training.

The Treatment Squad of the Medical Platoon operates an aid station. Personnel are trained in more advanced trauma management (ATM) skills for treating battlefield casualties. These personnel also conduct routine sick calls for unit members.

Level Two medical support transitions soldiers who need more advanced care into the hospital portion of Health Service Support. A soldier passing through the division medical system receives Level II care at the divisional clearing station operated by the company treatment platoon. As with other levels, the patient is treated and returned to duty or evacuated further to the rear. Emergency care can be continued. Treatment focuses on measures dictated by immediate necessities.

Level Three and Four care moves the patient into one of the corps/theater hospitals. At this point we find a significant change in the the system of Health Service Support.

B. Health Service Support-Futures (HSS-F)

HSS-F eventually will replace the current seven hospital system with four hospitals. There will be two corps-level hospitals, a 30-bed Mobile Army Surgical Hospital (MASH) and the 296-bed Combat Support Hospital (CSH). The two hospitals at echelons above corps (EAC) include the 516-bed Field Hospital (FLD) and the 476-bed General Hospital (GH). Gone from the force will be the, Evacuation Hospital and the 300-bed and 500-bed station hospitals.

Even though some of the names remain the same, the mission, internal design, and staffing have changed.

Each hospital has a specific mission as well as the capability of handling all categories of patients. With the exception of the MASH, these hospitals provide an inpatient acceptance role for the area support mission.

The CSH, FLD, and GH are designed using a modular concept. This permits incremental increases or decreases for mission adaptability and unit reconstitution. The base component (module) is clinically identical in all facilities. One or more mission-adaptive component(s) are added to form the individual hospital and are assigned separate tables of organization and equipment (TOE) to pre-identify personnel and equipment.

The MASH and CSH are employed as corps Level III medical facilities. The FLD is a Level III facility employed in the communications zone (COMMZ) along with GH, a level IV facility.

The 100% mobile MASH operates in the Division Support Area or just outside the of the division rear boundary. The MASH and CSH can deploy

in the COMMZ if required. The FLD can be used in the corps area if needed. Terrain, availability, combat operations, evacuation policy and other factors will dictate geographical locations.

The balance of this section will describe each hospital in more detail and describe critical differences from the old seven hospital system.

Mobile Army Surgical Hospital (MASH):

The MASH's primary mission is to provide surgical care and hospitalization for those non-transportable patients prior to evacuation to the Combat Support Hospital. The major capabilities of the unit include: (a) Lifesaving surgery and stabilization; (b) 30 acute care beds; (c) Ability to deploy a forward surgical team (FST); (d) Limited pharmacy, laboratory and x-ray services; and (e) 100 percent mobility. The MASH has a staff of 133 personnel.

The major changes from the old MASH are the reduced size of the unit, use of light weight equipment, and performance only of life-saving surgery. The casualties received in the facility are very unstable, with a high mortality rate.

Combat Support Hospital (CSH)

The CSH's primary mission is to provide resuscitative surgery and trauma treatment prior to evacuation and, secondly, provide a Return to Duty (RTD) capability commensurate with the evacuation policy. The 296 beds are divided into eight intensive care units (ICU), seven intermediate care wards (ICW), two minimal care wards (MCW), and one neuropsychiatric care ward.

The major capabilities are: (a) Resuscitation and initial wound surgery; (b) Medical treatment of critically injured or ill patients; (c) General and specialized surgery utilizing eight operating room tables; (d) A broad mix of nursing services; and (e) Limited physical therapy. The CSH has a staff of 605 personnel.

The significant changes in this hospital are the increased number of ICUs and operating room tables and the presence of the neuropsychiatric ward. This hospital essentially is a TRAUMA center.

Field Hospital (FLD)

The Field Hospital's primary mission is the hospitalization and rehabilitation of those patients who will return to duty. The 516 beds are divided into three ICUs, seven ICWs, two MCWs, one neuropsychiatric care ward, and seven convalescent care wards.

The major capabilities include: (a) General and orthopedic surgery; (b) Large RTD capability; (c) Occupational and physical therapy. The Field Hospital has a staff of 444 personnel.

The most significant change in the FLD was the incorporation of 280 cots to support a major thrust in RTD capability. This is the equivalent of seven convalescent care wards.

General Hospital (GH)

The General Hospital provides the only Level IV care in the theater. It has a primary mission of further stabilization prior to evacuation out-of-theater and returning to duty those patients who meet the established theater evacuation policy. The 476 beds are divided into eight ICUs, sixteen ICWs, two MCWs and one neuropsychiatric care ward.

The major capabilities are: (a) General and specialized surgical and medical services; (b) Eight operating room tables; (c) Occupational and physical therapy; and (d) A broad mix of nursing services. The General Hospital has a 741-person staff.

The major change in this type of hospital is the reduced size 1000 beds to 476 beds with the increased intensive care capability. The hospital is a fixed facility and is not mobile.

C. A Religious Support Concept for the Hospitals

The principle "Care of the Casualty" forms the basis of a religious support concept for the Medical Force 2000 hospital system. The new FM16-1, *Religious Support Doctrine: The Chaplain and Chaplain Assistant,* describes eight types of religious support. These are the foundation for describing a future religious support concept. These eight types of religious support are:

Ministry of Presence
Ministry to the Dying
Ministry of Sustaining
Crisis and Stress Ministry
Sacramental Ministry
Ministry of Guiding
Ministry of Worship
Ministry of Celebration

The diagram gives a quick summary of these eight types of religious support.[2]

UMT RELIGIOUS SUPPORT TO CASUALTIES	
TYPES OF RELIGIOUS SUPPORT	DEFINITIONS
MINISTRY OF PRESENCE	Being actively present and available to casualties
MINISTRY TO THE DYING	Providing specialized ministry for those whose death is imminent and/or probable.
MINISTRY OF SUSTAINING	Helping the seriously wounded or ill whose conditions will not change in the near future to move beyond present circumstances, toward hope.
CRISIS AND STRESS MINISTRY	Helping those in crisis to cope.
SACRAMENTAL MINISTRY	Providing specific religious ministration common among religious groups.
MINISTRY OF GUIDING	Assisting soldiers to make responsible decisions.
MINISTRY OF WORSHIP	Leading soldiers in prayer, praise, thanksgiving, meditation on sacred writings, and in recommitting themselves to religious life.
MINISTRY OF CELEBRATION	Providing opportunities for soldiers to express their thanksgiving and praise to God and others for protecting them on the battlefield and for contributing to their well-being.

[2]*Ibid.*, p. 5-20.

All UMTs provide these types of religious support. At any one time, one or more may receive emphasis. All are important for the overall religious support mission. One challenge of hospital ministry is assessing the needs of patients and staff in applying these types of support.

Battlefield conditions, patient evacuation policies, and extent of patient wounds are among the many influences on the religious support emphasis. Another helpful influence is to consider the type of hospital involved. Each hospital type in the Medical Force 2000 system is unique and requires a specific ministry focus. UMTs assigned to hospitals can gain insight into the kind of ministry required from an understanding of the hospital mission. The following material suggests a ministry concept for each of the Medical Force 2000 hospitals.

MASH

The MASH emphasizes life-saving efforts. Patients are highly unstable and subject to frequent fluctuations in conditions. Patients receive surgery and other life-sustaining efforts to become stable before further evacuation. The short expected stay (24-36 hours) means the direct religious support will be limited. The MASH has one UMT.

The concept of religious support in the MASH includes ministry of presence, ministry to the dying, and ministry in crisis and stress.

The UMT can provide a calming presence for the wounded and those who care for them. Injury or sedation may seriously reduce the patient's ability to talk. The UMT needs to be aware of the research showing the importance of visiting and talking to even a comatose patient. Such presence can prove to be a valuable resource in the healing process. Another important aspect of ministry of presence is the support which the UMT can provide the staff under highly stressful conditions.

Under battlefield conditions, the medical personnel will focus on those wounded soldiers most likely to survive. Ministry to the dying will be a major focus of the UMT. Based on triage decisions, the UMT will focus attention on those soldiers identified with the greatest risk of dying. Religious rites which provide assurance and spiritual strength will be important at this time.

Crisis and stress ministry gives the UMT a chance to help soldiers cope with the crisis in which they find themselves. One important part of this ministry is giving staff members a chance to debrief their work. Research with rescue workers and others who experience high stress work shows that a debriefing is important for emotional health. The experienced UMT has skills for conducting effective debriefings. Essentially, this involves facilitating discussions about the work and feelings generated by such work. This can be done individually or in a group setting. It is crucial that discussion take place. Debriefing sessions will enable the staff to work together in greater harmony. It will also reduce the incidence and severity of future Post-Traumatic Stress Disorder (PTSD) among staff members. The short-term benefit might be a prevention of debilitating combat fatigue in the staff. The skilled UMT can help those in crisis use the resources of their faith in coping.

Opportunities for worship, counsel, and support of staff by the UMT will help staff members cope with the extremely stressful and difficult tasks which they face on a continuous basis. As this occurs, the staff will better serve the soldiers brought to the MASH for medical care.

The MASH has the operational capability of deploying a Forward Surgical Team (FST) to a second location. The team will have a general surgical capability to provide 24 hours of surgery and one 10-bed ward for pre-operative and post-operative acute nursing care. The team enhances the ability to provide surgical support close to the locations of greatest need. The team will attach to a medical unit the Division/Brigade Support Area. The UMT of the receiving unit needs to be aware of its presence and provide religious support to the team members during the time of attachment.

Combat Support Hospital

The Combat Support Hospital (CSH) is similar to a trauma center. Religious support will be more diverse than in the MASH. Approximately 20% of the patients will return to duty from the CSH. The other 80% will be in critical condition and experience further evacuation. The UMT will have a crisis and stress ministry for the life-threatened as well as more supportive or guiding approach to the patients returning to duty. The CSH will have two UMTs to accomplish the mission.

The task of religious support to trauma patients may seem overwhelming. A full census will mean 96 intensive care patients and a total of 296 patients. Handling that many ICU patients without other requirements will tax the UMTs extensively. Training in a trauma center will provide skills needed for this religious support mission. Caring for these patients will require the UMT to use skills related to ministries of presence, dying and sustaining. These skills enable the UMT to assist patients move beyond the crisis of the moment towards hope.

The sense of crisis and stress caused by the critical condition of most patients will influence all that the UMT does in its religious support mission. Unfortunately for the staff, the stress doesn't end with the patient conditions. Operationally, the CSH can plan to move every seven to ten days. This mobile capability will prove a very stressful one because of difficulty moving the high number of intensive care patients. The UMT needs to be acutely sensitive to the effects of relocation on patients and staff. Sacramental ministry and ministry of presence will be important supporting ministries in this stressful environment.

Those few patients who will return to duty from the CSH many need assistance coping with guilt about surviving or fear over participating in further conflict. Ministry of guiding will help enable soldiers handle these concerns. Ability to lead small group discussions will assist the UMT maximize its use of time. Soldiers who can share their experiences, fears and guilt with other soldiers may soon find they are among friends with similar concerns. Knowing they are not alone is an important discovering for these soldiers.

The CSH has a 20-bed neuro-psychiatric ward. The UMT will benefit from experience with patients whose dysfunction may be more emotional than physical. Close interaction with the mental health staff will be important in developing a shared treatment plan. In some cases the chaplain's work will approach psychotherapy. In others, sacramental ministry may be more helpful. The ability to help some patients think through their own religious problems will be important on this ward.

Field Hospital

The varied nature of the Field Hospital wards (Intensive, Intermediate and Minimal care, as well as neuro-psychiatric), will provide the UMTs a greater variety and intensity of patient conditions for religious support. Opportunities will exist for crisis ministry and also guiding, worship and celebration.

The Field Hospital's primary mission of treating up to 280 RTD patients calls for a religious support emphasis on the skills that sustain and support the soldier emotionally and spiritually. This hospital is authorized three UMTs. These teams likely will have more time to develop a supportive relationship with the soldier because of the RTD status. The patient will require less direct medical care in preparation for discharge. This will be a good time to assist soldiers face the fear associated with a return to battle. There likely will be guilt for surviving, as well. Group and individual discussions will be helpful in the transition. The ministries of guiding, worship and celebration will help the soldier connect faith issues to the feeling generated by survival and the anticipated return to duty.

Religious support for the hospital staff will also emphasize the supportive approach of guiding, worship and celebration. The staff, like the patients, will benefit from the opportunity to integrate their spiritual concerns with their daily work and celebrate the presence of God in their lives.

General Hospital

The General Hospital has the greatest mix of patients. Working with patients and staff the UMT will find opportunity to use all eight types of religious support ministry. Some will require the supportive and sustaining emphasis to face the reality of Return To Duty. The majority of patients will evacuate to the CONUS-based hospitals. The UMT will watch for possible guilt associated with returning home while friends and other soldiers do not. Assisting the soldier to talk through feelings of survivor guilt will be a most valuable focus of religious support. Identifying religious issues and resources around guilt will be important to the soldier's recovery.

Religious support through worship, counsel, sacraments, presence, etc. are all important in completing the religious support mission.

Conclusion

Looking at the hospital unit types will give the UMT an opportunity to consider the emphasis needed for ministry. Those UMTs assigned to the

MASH or CSH will find crisis skills, especially involving severe trauma and death, essential. Experience with the impact of death on the medical personnel, as well as on patients, will be crucial for understanding ministry in these hospitals. Skills for staff debriefing and support will assist the staff function more effectively.

Those UMTs assigned to the Field or General Hospitals will benefit from experience with a broad range of hospital patients.

Regardless of hospital supported, the UMT needs to remember that it is not immune to the stress and trauma it addresses. UMT personnel will struggle with themselves as they try to prop-up others. Religious support and stress intervention will be important for empowering the UMT to carry out its mission. Awareness of the conditions under which they will function, and practice of religious support skills in current traumatic situations are crucial preparation for the UMT.

The Army's Health Service Support is in a state of change. The refinements of Health Service Support-Futures will continue over the next few years. Changes in concept is one factor in changes we will see in the structure of Medical Force 2000. Each change strives to improve the Army's ability to "Conserve Fighting Strength." As the Army adjusts its Health Service Support, the UMT needs to look at the changes for possible impact on the personnel and methods for providing and performing religious support to casualties and medical personnel.

Discovering Army Medical Ethical Issues

John Brinsfield
Al Isler

Introduction

In the summer of 1989, Chaplain (COL) Robert Campbell, Staff Chaplain for U.S. Army Health Services Command, invited the authors of this article to assist in planning for a conference on medical ethics on the battlefield. Chaplain Brinsfield was to deliver an address on military ethics as related to the health care professions. Chaplain Isler was to assist Chaplain Brinsfield in the development of the address, and, in addition, serve as a small group facilitator for the discussion of medical ethical issues at the conference which was scheduled for May, 1990.

We realized quite early in the planning process that the scope of the presentations and the discussions at the conference could be quite broad, given the professional expertise of the 250 physicians, nurses, medical service corps personnel, chaplains, chaplain assistants, attorneys, and commanders expected to attend. We wanted to try to discover in advance what the health care team professionals considered to be the most important contemporary medical ethical issues on the battlefield. This information would help us design our address and small group discussions to meet the needs and interests of the people attending.

With the assistance of Chaplain (LTC) David DeDonato, Project Officer for the Conference, Chaplain (COL) Max Burgin, Staff Chaplain at Walter

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Chaplain (LTC) John Brinsfield, who holds a Ph.D. from Emory University, and a D.Min. from Drew University, has served as an assistant professor at the United States Military Academy, and has taught at the U.S. Army Chaplain Center and School. He was most recently assigned to 3d PERSCOM, Operation Desert Storm. He is a United Methodist Minister.

Chaplain (MAJ) Albert Isler is a writer/instructor at the U.S. Army Chaplain Center and School. Prior to this he was assigned to the 3rd U.S. Infantry Regiment (the Old Guard). He received an M.Div. from Concordia, and a Th.M. from Princeton, and is endorsed by the Lutheran Church, Missouri Synod.

Reed Army Medical Center, Chaplain (COL) Lindell Anderson, Director of Military Ministries at the Army Chaplain School, we developed and staffed a very simple questionnaire for health care team professionals. We asked for written responses to the following three questions:

1. In your opinion, what are the three most important ethical issues for a health care provider team on the battlefield?
2. What is the role of the health care provider team in advising the commander?
3. What ethical values, not currently in Army doctrine, should be recommended for all health care provider teams?

We sent the questionnaires to Walter Reed Army Medical Center, to the United States Army Chaplain School, and to the pre-registered conference attendees in March, 1990. These were, of course, three different groups in three different locations. By May 10, we had received 51 total responses from Walter Reed AMC and from the Chaplain School. On May 14, the first day of the conference in San Antonio, we received 161 responses from the attendees in the initial discussion group meetings. Approximately 90 participants discussed the issues at the conference but did not return their written responses.

Analysis of Responses

The 51 Walter Reed AMC and Chaplain School responses to the first question identified the top three ethical issues as follows:

1. Triage of patients and priority of care for the wounded (34 responses).
2. Priority of treatment for enemy prisoners of war versus allied soldiers and civilians (25 responses).
3. Allocation of scare resources to include medicine and supplies (25 responses).

The 161 conference health care professionals, responding independently and without prior knowledge of the other two groups' answers, concurred with exactly the same three issues:

1. Triage of patients and priority of care for the wounded (75 responses).
2. Priority of treatment for enemy prisoners of war versus allied soldiers and civilians (70 responses).
3. Allocation of scare resources to include medicine and supplies (34 responses).

Moreover, of the 29 issues mentioned on the Walter Reed AMC and Chaplain School questionnaires, 20 were virtually identical with the questionnaires returned at the conference. The similarity among these independent responses should reflect high validity and confidence in the issues as matters worthy of discussion in all deployable Army health care teams.

The percentages of total responses for the top three issues among the three groups surveyed are depicted in the chart below:

RESULTS OF MEDICAL ETHICS QUESTIONNAIRES

The following top three issues dealt with decision-making:

1. "Triage of patients and priority of their care."

   47% San Antonio
   67% WRAMC, USACHCS

2. "Priority of treatment for enemy POW, versus allied soldiers, versus civilians."

   43% San Antonio
   49% WRAMC, USACHCS

3. "Allocation of scare resources to include medicine and supplies."

   21% San Antonio
   49% WRAMC, USACHCS

The percentages suggest that while about half of the responses were grouped around these three issues, the other half were scattered among the other 28 issues mentioned by the three groups of respondents. The entire list, or universe, of 31 ethical issues from all three groups revealed concerns with ethical decision-making, conduct, and policies as indicated below:

Ethical Issues Identified: (Conference Responses)

a. Triage of patients and priority of care decisions (75).
b. Priority of treatment for enemy prisoners of war, allied soldiers and civilians (70).
c. Allocation of scarce resources to include medicine and supplies (34).
d. Abandoning expectant patients in combat; decisions involving kind and length of treatment for expectant patients' allowing the patient the right to die; deciding who will live or die (26).
e. Reporting/committing violations of the law of land warfare to Geneva Conventions (21).
f. Ethical behavior within the medical unit itself; setting and enforcing high standards (19).
g. Use of medical personnel as combatants (12).

h. Decisions concerning return to duty (11).
i. Treatment of patients exposed to nuclear, biological, or chemical contamination to include communicable diseases (8).
j. Taking care of oneself; avoiding panic; evaluating risk to unit and to self (8).
k. Courage and accuracy in advising the commander of information which may have a negative impact on the unit (7).
l. Decisions concerning evacuation policy of patients to "safe" areas (6).
m. The ethical imperative of realistic training, especially scenarios, to develop competency in ethical decision-making (6).
n. Conflict between military tactical plans and patient care; location and movement of aid station with respect to constant flow of causalities (4).
o. Dealing with combat stress; priority of treatment for battle-fatigue patients (4).
p. Truthful disclosure to patients, medical personnel, and the commander (4).
q. Medical experimentation during war (3).
r. Providing truthful information to families of casualties (3).
s. Assigning female nurses to units in close combat (3).
t. Proper interaction between chaplain assistants, chaplains and medical personnel (3).
u. Following orders which have patient deaths as a secondary effect (3).
v. Coping with non-combatant death due to "friendly fire" (2).
w. Discrimination (racial, rank, occupation, gender) in treatment (2).
x. Use of health care as a combat multiplier (2).
y. Recovery after combat/mass casualties; answering the question, "why?" (1).
z. Costs of high-tech medical treatment as a factor in patient care decisions (1).
aa. Emotional health of medical personnel on extended duty (1).
bb. Maintaining confidentiality of patient disclosures and personal effects (1).
cc. Treating the dead with dignity (1).
dd. Treatment priority for psychological casualties (1).
ee. Maintaining confidentiality of records (1).

A table of responses from the conference attendees by occupation shows a good deal of consensus by the medical service corps, the physicians, the nurses, and the chaplains concerning the most important issues:

"MEDICAL ETHICS ON THE BATTLEFIELD"
161 QUESTIONNAIRE RESPONSES BY OCCUPATION/MOS

ISSUE	UB4	PA4	MSC27	CA3	JAG1	PHYS17	N44	CH61	TOTAL
a.	2	3	12			6	17	35	75
b.	2	1	11	1	1	8	23	23	70
c.	2	1	5			8	12	6	34
d.		1	2			3	13	7	26
e.			3		1	1	4	12	21
f.	1		4		1	3	7	3	19
g.			4			2	3	3	12
h.			1		1	2	1	6	11
i.		2	2				1	3	8
j.								8	8
k.								7	7
l.				1	1		1	3	6
m.				1			3	2	6
n.			1	1		1	1		4
o.				1			1	2	4
p.								4	4
q.						2		1	3
r.							3		3
s.							2	1	3
t.				1				2	3
u.			1					2	3
v.			2						2
w.				1		1			2
x.								2	2
y.			1						1
z.							1		1
aa.							1		1
bb.							1		1
cc.								1	1
dd.								1	1
ee.	1								1

KEY: UB=unidentified branch, PA=physician's assistant, MSC=medical service corps, CA=chaplain assistant. JAG=judge advocate general, PHYS=physician, N=nurse, CH=chaplain.

Note:
a. Issues are in small case to correspond with descriptions in paragraph 4.
b. Numbers next to Occupations/MOSs = number of returned questionnaires.
c. Numbers in columns = responses to each issue.

The responses from the small groups at the conference further validated two of the top three individual questionnaire results. Chaplain (MAJ) Al Isler noted that the following issues were reported as most important by four or more groups working independently:

a. Triage of patients - 14 groups.
b. Priority of treatment for EPW's, allied soldiers, and civilians - 8 groups.
c. Providing care to expectant patients "as patients, not numbers" - 4 groups.
d. Providing adequate training, doctrinal, physical and emotional, for readiness - 4 groups.

Although 16 of the 31 issues identified by the three professional groups dealt with *ethical decision-making*" involving patients, 15 (or about 50%) dealt with *"ethical behavior"* by members of the health care team themselves. It was clear that the members of the teams look to their leaders not only to make good decisions but also to set and model decent ethical and moral behavior as well. Medical ethics, like medical treatment, was seen as a team concern with high expectations for leadership and training.

Providers' Roles Identified:

We asked all participants the following question: "What is the role of the health care provider in advising the commander?" This question brought the following 16 suggestions from the questionnaires:

- The Health Care Team apprises the commander of all health care issues under all condition to include:
  - Treatment of soldiers in timely manner. Priority of care. Number and kinds of casualties.
  - Treatment of civilians and EPW's
  - Reporting on morale and health care expectations of patients, emotional well-being. Predicted level of health in future, status for each battle option.
  - Any moral or ethical issue or violation of human rights or dignity.
  - Implementation of triage principles (example: ignoring enemy seriously wounded).
  - Violations of medical immunity (storing ammo in ambulances) Violations of laws of war.
  - Potential diseases & medical problems.
  - Advice prior to combat, level of training before combat.
  - Experiments on patients
  - Goals and standards of ethical health care he/she may expect.
  - Proper use of medical assets, units, personnel.
- The Health Care Team must be totally reliable and accept responsibility for recommendations.

- Set the example, enforce rules, reward ethical conduct.
- Reinforce team concept, total welfare of people, good leadership - no drug use, drinking on duty, immorality.
- Advise on needs (supplies, reinforcement, rest, equipment). Plan for battle conditions, mass casualties, assets.
- Consider workload factors, fatigue among medical personnel, welfare of troops.
- Keep commander from being "de-sensitized."

What Values are Needed?

The third question, "What values, not currently in Army doctrine, should be recommended for all health care provider teams?," drew the fewest responses. Some participants did not know what the term "values" meant. Eighty-eight of the participants left this question blank or indicated that they did not know what Army doctrine contained. We believe that if the question had been changed to read, "What moral or ethical guidelines should be recommended for all health care provider teams?" the responses would have been better. The following responses to question three, as originally worded, were made by small groups:

- Decision-making should be by teams rather than by one individual commander (a committee approach to ethical decisions). (3 groups)
- Options in consenting to treatment should be made available to patients. (1 group)
- Socialization of soldiers after battle is important. (2 groups)
- Policies concerning handling immoral behavior in health care teams must be enforced. (2 groups)
- A discussion of full disclosure vs. harmful effects of the whole truth on a patient should be held. (2 groups)

The following were verbatim responses from individual questionnaires to the question about values:

- Female soldiers on the battlefield.
- Selflessness.
- Never forget the troops.
- Responsibility to civilians.
- Medical ethics training *before* combat.
- Appropriate times for armed self-defense.
- How to deal with superiors in resolving ethical conflicts.
- Who keeps me straight?
- Love your neighbor as yourself.

Conclusions

Our analysis of the questionnaire responses and comments from the small groups at the medical ethics conference yielded the following conclusions:

1. The top three medical ethical issues dealt with prioritizing patient care and allocating resources for such care on the battlefield. Underlying these issues was the *recognition of possible role and value conflicts* for health care team members in making difficult prioritizing decisions.

2. Most members of the health care team felt it was their duty to *advise the commander on all aspects of health care related to their mission under all conditions of war.* This advice included any information on possible violations of the laws of war revealed to health care members.

3. Many of the respondents did not know what medical ethical principles the Army advocated in doctrine. Many had problems with definitions of terms such as values, morals and ethics. *Almost all of the respondents desired more training in medical ethics. Some said that the lack of such training was itself an ethical issue.*

We believe that more ethical training, to include the production of comprehensive doctrinal publications in medical ethics, was mandated by the conference attendees. Yet it was also clear from almost half of the responses to the questionnaires that training alone would not address all of the concerns of the group. Ethical leadership in "setting the example" and enforcing ethical standards was just as important.

One suggestion by the conference attendees to facilitate both good training and good leadership in medical ethics was to utilize an ethical decision-making model for emergency situations. Their proposed model was a simple analytical one tailored to the four medical ethical principles of *beneficence* (promoting the greater good), *non-maleficence* (avoiding harm), respect for *autonomy* (treating the patient as individuals, not as means to an end), and *justice* (fairness for all) borrowed from Tom Beauchamp and James Childress' *Principles of Biomedical Ethics.* The model had six steps:

- Determine the facts. What decision must be made?
- Define the concepts. What do the medical and ethical terms mean?
- Examine the medical ethical principles of beneficence, non-maleficence, autonomy and justice as they apply to the immediate situation.
- Discuss the constraints. What professional or command guidelines must apply?
- Outline the courses of action. What are the advantages, disadvantages and consequences of each? Consider material resources and cost to future care, as well as patient needs.
- Make the best decision possible for all concerned and be responsible for it.

From many written and verbal comments we concluded that the conference participants believed that medical ethics must be as reasonable as any other life issue. They further expressed great need for additional guidance and training to address the issues they raised in order to do not only what is necessary in time of war, but also what is right.

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The Preservation of Life - An Ethical Overview

Thomas J. Naughton

The whole world was watching when, in April 1976, the New Jersey Supreme Court was asked to rule in the case of Karen Ann Quinlan. Her parents had petitioned the court for permission to remove Karen from a respirator which had been started for her when she suddenly lapsed into a deep coma on April 15, 1975. Karen's father had petitioned the Superior Court for removal of the respirator in November 1975 and the petition had been denied. On April 1, 1976, the Supreme Court of New Jersey reversed the decision of the lower court, and the respirator was removed so that Karen might be allowed to die.

Karen's parents had consulted medical experts and medical ethics experts in reaching their heart-rending decision. They did not want to take their daughter's life; they wished only that the course of nature be permitted to take over and release Karen from a persistent vegetative state. Even after the removal of the respirator, it was several years before Karen died.

The Karen Ann Quinlan case was a landmark in legal jurisprudence and in medical ethics. Prior to the decision of the New Jersey Supreme Court, medical and ethical experts showed great hesitation in discontinuing any treatment once it was started. They still do.

How did medical ethics come to where it is today in its outlook on the preservation of life? What is in the future?

The World After World War II

It may seem arrogant and presumptuous of us to discuss a "modern age" of medicine and ethics, as if ancient writings could tell us nothing. To ignore the Hippocratic oath and the writings of the Greek physician, Galen, would be folly. The principle, *primum non nocere* (above all, do no harm) of ancient physicians and the Hippocratic oath have withstood the test of time. They are as relevant today as the day they were written.

Chaplain (LTC) Thomas J. Naughton, the Deputy Post Chaplain at Carlisle Barracks, PA, was educated at Boston College, received a M.A. in Theology at St. John's Seminary, a M.Ed. from North Carolina State University, an M.Div. from Cathedral College, Queens, NY, and is CPE trained. He has served in Vietnam and twice in Korea. He is a Roman Catholic priest.

Contemporary writers, however, tell us that World War II was extremely significant in the history of medicine. Two central issues confront modern medicine and ethics in the aftermath of the war.

The first issue is that battlefield surgery in the war was a quantum leap in medicine. For the first time in modern history, casualties were treated quickly, close to the front lines, in field hospitals and aid stations. Innovative surgery and new drugs such as sulfa and penicillin were responsible for saving many lives that would have been lost in previous centuries. We were now faced with the issue of prolonging life and saving life, sometimes by experimental means and extraordinary means.

The second issue came out of a horrible precedent. Wanton experimentation in the concentration camps shocked humanity. The experimentation was carried out without regard for human dignity or any ethical constraint. Once the war was over and the criminals punished, the good that might come from animal and human experimentation was examined. Ethicists had to weigh the value of the human person against the possibility of curing previously incurable diseases and advancing the science and art of medicine.

In the explosion of knowledge after the war, many ethicists and theologians came forward to assist the medical profession and the world in addressing the moral questions involved in the new medicine. Among the early writers in the Protestant world, the best remembered names would include Karl Barth, Paul Ramsey, H. Richard Niebuhr and Joseph Fletcher. The Catholic world gave us Francis Connell, CSSR, John Ford, SJ, Gerald Kelly, SJ and Bernard Haring, CSSR. Many other ethicists and theologians wrote in those early post-war years. The names given above are not proposed as an exhaustive list, merely representative, and rather parochial, since they reflect only a Christian context.

In those early post-war years all ethical writers took notice of directives that came from persons and organizations such as the American Medical Association, the Catholic Hospital Association (US) and the Constitution of the World Health Organization under the auspices of the United Nations. The earliest response to the atrocities of World War II in the matter of medical ethics came from Nuremburg Code of 1949.[1]

In Catholic circles, the central figure was Pope Pius XII. After the war, Pius spoke and wrote of many medico-moral issues such as euthanasia, sterilization, experimentation and organ transplantation.

During the time that Pius XII was pope (1939-1958), a book was written in Rome by a priest working on a doctorate in theology in Rome's Gregorian University. This book, published in 1956, was entitled, "The Moral Law in Regard to the Ordinary and Extraordinary Means of Conserving Human Life."[2]

[1]"Trials of War Criminals Before the Nuremburg Military Tribunal Under Control Council Law Number 10", Volume 2, Washington DC: US GPO 1949, pp 181-182.

Cf. also, The Declaration of Helsinki, World Medical Assembly, 1964 and Ethical Guidelines for Clinical Investigation, by the American Medical Association, November 30, 1964.

[2]Cronin, Daniel A., "The Moral Law in Regard to the Ordinary and Extraordinary Means of Conserving Human Life", Pontifical Gregorian University, Rome, 1956. (At present, the author, Most Rev. Daniel A. Cronin, is Bishop of Fall River, MA.)

This doctoral thesis of Fr. Daniel Cronin marked a significant milestone in the study of medical morality in delineating for the first time a clear distinction in terms: ordinary means, extraordinary means and common means of preserving life. In the year after the publication of the thesis, Pope Pius XII used the terms in addressing a group of medical specialists, stating that there is a moral obligation to use ordinary means to preserve life, while there is no obligation to use extraordinary means.[3] This significant milestone is important not simply because a Pope used the terminology. Rather, the terminology achieved a pivotal position in medical ethics publication when many other theologians adopted the terminology in speeches and publications.

Descriptively, the word 'ordinary' refers to medical intervention, whether surgical or pharmacological, that is standard practice in the treatment of a diseased condition. 'Extraordinary' would connote a treatment that is experimental, risky or involving severe pain, with only a marginal probability to success 'Common' refers to the simple providing of food and drink in the normal manner.

In his work, Father Cronin raised questions with tremendous implications then and of greater importance. The questions were whether 'ordinary' means could become 'extraordinary' in certain circumstances and whether even 'common' means could be considered 'extraordinary.' To illustrate the first consideration we might ask whether a patient would be required to undergo the removal of an inflamed appendix if he were also in the very advanced stages of terminal metastatic cancer. Would a kidney transplant be appropriate or necessary for a patient who is terminally ill from cancer or amyothrophic lateral sclerosis? Or, would a patient in the last stages of leukemia be required to endure uncomfortable transfusions or kidney dialysis? To push the analogy even further, one might ask if a patient whose stomach is ravaged by cancer should be forced to use food (a 'common' means) when it would only provoke massive infection and extreme discomfort. In these cases, it would seem 'ordinary' and 'common' means of preserving life could be considered 'extraordinary' and a patient would not be required to use them.

The stance of Father Cronin was based, in his mind and methodology, on principles. Much of his writing and the statements of Pope Pius XII were reaction to a growing school of "situation ethics" that was best represented in the work of Joseph Fletcher:

> Every little book and manual on 'problems of conscience' is legalistic. 'Is it right to . . . . .' have premarital intercourse, gamble, steal, euthanase, abort, lie, defraud, break contracts, *et cetera, ad nauseam*? This kind of intrinsicalistic morass must be left behind as irrelevant, incompetent and immaterial. The new morality, situation ethics, declares that anything and everything is right or wrong, according to the situation.[4]

It would be wrong to portray Fletcher as unprincipled or without morality. Perhaps his stance is best represented thus:

[3]Pius XII, "The Prolongation of Life," *The Pope Speaks*, Volume 4, 1957-1958, pages 395-396.

[4]Fletcher, Joseph, "Situation Ethics", Westminster, Philadelphia, PA, 1966, page 124. (All interruptions and emphasis are in the original text.)

> Situation ethics keeps principles sternly in their place, in the role of advisers, without veto power. Only one 'general' proposition is prescribed, namely, the commandment to love God through the neighbor.[5]

The illustrations used above in discussing whether 'ordinary' or 'common' means can become 'extraordinary' have been used by Father Cronin and many other writers in the years since 1956. These situations seem frightfully simple and straightforward if one compares them with the most controversial issues of our day: right to die legislation, the living will, the removal of life support systems, the writing of do-not-resuscitate orders and the providing of nutrition and hydration to comatose patients, or to use other terminology, those in a persistent vegetative state. That brings us back to Karen Quinlan and some other agonizing decisions in medical ethics.

The Greatest Challenge in Today's Medical Ethics

> Crista Nursing Center is a 271-bed nursing home Seattle with a 35-bed nursing wing. In 1984-1985 two families, after learning from the attending physician and two consulting doctors that death was imminent for their elderly dear ones, requested the removal of the nasal-gastric feeding tube. The patients had been diagnosed as being in a persistent vegetative state. Six of the twelve nurses in the nursing wing refused to act on the request. Nancy Farnam, one of the resisting nurses, stated: "They are trying to make us the executioners. And I don't like that."[6]

The greatest challenge in the present-day study of medical ethics is that called nutrition/hydration. This, qualitatively, is a step beyond the 'common' means of preserving life by eating and drinking. Modern medical practice can sustain persons in what is termed persistent vegetative state (PVS) by introducing intravenous feeding, naso-gastric tubes and by surgical intervention that introduces a feeding tube through the abdominal wall directly into the stomach. The challenge, then can be seen as two-fold. First, when does medical morality allow or demand that such procedures be initiated? Consequent upon this is the question of ethics of discontinuing such treatment once it has been started.

In the case of Karen Quinlan, the issue placed before the New Jersey Supreme Court was the discontinuation of respirator support. When that was removed, Karen lived for some years, receiving nutrition and hydration. Her family asked that she be removed from the respirator with court authorization and advisories from family clergy on the ethics of that action, hoping that her condition was such that, once the respirator was removed, the natural course of her injury or disease would *allow* her to die. No ethicist or physician could choose an action which would *cause* her to die, which would be tantamount to euthanasia.

In recent years, medical advances have been made which make it possible to provide nutrition and hydration more easily. So, we are not faced with the

[5]Ibid. page 55.

[6]McCormick, SJ, Richard A. "The Critical Calling", Georgetown Univ. Press, Washington, DC, 1989, page 369.

question of whether we can do it. The two questions now posed to doctors and moralists are: "Should we start?"; and "Once we have started, can we stop?"

Three cases from the 1980's have provided lawyers, judges, physicians and ethicists with much food for thought about the issue of nutrition/hydration. Paul Brophy was a Massachusetts man who was comatose after surgery for a cerebral aneurysm. Claire Conroy was an eighty-four year old nursing home patient who suffered irreversible impairment in the wake of arteriosclerotic heart disease, who was not comatose, but was not able to communicate. Clarence Herbert, a Californian, suffered a cardiorespiratory arrest during surgery and suffered severe brain damage; he was in a persistent vegetative state.

Court rulings were sought for all three persons in their respective states. Massachusetts would not sanction removal of nutrition from Paul Brophy because to do so was viewed as *causing* his death. For Claire Conroy, the New Jersey court, which had ruled in the Karen Quinlan case, refused to allow the cessation of nutrition and hydration because the full reality of her situation did not meet the criteria of persistent vegetative state. The case of Clarence Herbert came to the California courts in a very unusual way. Clarence's family made a written request that support be discontinued and he be allowed to die. The medical staff complied. The doctors were charged with murder by the California legal system in 1983. One judge dismissed the charge; another judge reopened the case. In October 1983, an Appeals Court decision exonerated the doctors, classifying nutrition and hydration as medical procedures, comparable to extraordinary means, disproportionate in this case, and not obligatory.

The case which provoked the closest scrutiny among the legal, medical and ethical experts was the situation of Nancy Cruzan of Missouri. Nancy had been in an irreversible coma since an automobile accident seven years ago. Her parents asked that nutrition and hydration be stopped and cited that she had told a friend long before the accident that she would not want to live a life that could not be normal, conscious and productive.

Most states would allow parents or guardians to make decisions to discontinue life support systems according to their best judgment, with some safeguards built into the system to protect the right of the patient to life. Missouri's "living will" statute demands clear and convincing evidence before sanctioning such action, and the case of Nancy Cruzan did not fulfill the requirements. The case was taken to the United States Supreme Court in the 1989-1990 session.

By a vote of 5 to 4 the Supreme Court upheld the Missouri statute and refused to allow the removal of nutrition and hydration from Nancy Cruzan. In presenting the decision of the Court, Chief Justice William Rehnquist brilliantly outlined the issues of the right to refuse treatment, the protection of the incompetent, informed consent, the interest of the state in the preservation of life and the protection of the interests of the individual. Key to the decision of the Supreme Court was the "states' right" issue:

> In sum, we conclude that a state may apply a clear and convincing evidence standard in proceedings where a guardian seeks to discontinue nutrition and hydration of a person diagnosed to be in a persistent vegetative state.[7]

Reaching a Moral Conclusion

In the past couple of years there has been an incredible explosion of writing about nutrition and hydration. Church groups, university theological faculties and ethical foundations (such as the Hastings Center) have contributed to the study of the ethical and legal issues involved. One of the more finely nuanced studies has been the work of Fr. Richard McCormick, SJ.[8]

A very concise set of principles was put forth by the Catholic bishops of the state of Texas in May, 1990, while the Supreme Court decision in the Cruzan case was still in process. The principles are presented as a representative outline of current thinking on the subject:

1. Although life is always a good, there are conditions which, if present, lessen or remove one's obligation to sustain life.
2. If the reasonable foreseen benefits to the patient in the use of any means outweigh the burdens to the patient or others, then those means are morally obligatory.
3. If the means used to prolong life are disproportionately burdensome compared with the benefits to the patient, then those means need not be used; they are morally optional.[9]

Pastor, What Can I Do?

Coming to the end of this discussion one can ponder the incredible complexity of the issues involved. Further, there are questions that touch on the preservation of life that will take more study, more discussion, more writing. Only a few of these questions are: living wills, variations in legal criteria among the states, informed consent, doctor-assisted suicide, and right to privacy laws. The pastor of the 1990s and the 21st Century will need to be aware of the questions and be prepared to assist parishioners in discerning the answers.

To whom will the pastor minister?

First - to the patient. By all means first. Whether it is by Sacrament, prayer or presence, the patient is the primary concern.

Second - to the family. Here the pastor will encounter grief, hesitation, anger and a confrontation with the vagaries of law and ethical standards. Ritual, prayer and presence and an understanding heart will be as important as the pastor's knowledge of ethics.

[7]Text of the Supreme Court decision reprinted in *Origins*, Catholic News Service publication (Washington, DC) July 5, 1990, Vol. 20, Number 8, pages 127-132. Cited text is on page 131.

[8]Cf. note 5.

[9]*Origins*, "On Withdrawing Artificial Nutrition and Hydration", page 53. Volume 20, Number 4, June 7, 1990 (Catholic News Service, Washington, DC).

Third - Who will be with those people in the middle, like the nurse at the Crista Nursing Center, who as previously mentioned, did not like being made an 'executioner'?

Fourth - The pastor will be both the ethical advisor to the doctor as part of the heath care team and will be ready to care spiritually when the doctor, who is so dedicated to fight for life, is called upon to make the decisions which represent defeat in this world. Will the pastor and the doctor live in the hope of a life beyond this one?

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Caring for the Dying: An Ethical Perspective

Douglas F. Bailey

A few weeks ago I was in Honduras with a medical and dental team. Returning from a remote, mountainous village our truck slid off the road where there was a washed out shoulder and rolled sixty feed down the mountain. No one was seriously injured, but the next greatest fear became what kind of medical care could we expect in a third world hospital. We were anxious until our plane landed in Miami and we could be checked by a physician here. No one can deny that in this country we have the best medical care possible in the world. But this excellence comes complete with heart-wrenching dilemmas.

According to an ancient Greet myth, the goddess Athena procured two powerful drugs in the form of blood taken from the Gorgon Medusa, the blood from her left side providing protection against death, that from her right side a deadly poison. Athena gave both vials to Asclepius, the revered founder of medicine. We know today more than ever that medicine can both help and harm. The same tubes that make IVs so much more comfortable also senselessly prolongs the life of a irreversibly comatose young woman. The same morphine that reverses the respiratory distress of pulmonary edema can, in higher doses, arrest respiration altogether. There is need for great wisdom in the use of these vials.

In this article, I would like to present an overview of ethical treatment of the dying patient. The liminal issue to be addressed revolves around caring for a terminal patient especially a patient in a persistent vegetative state. As an ethicist I must be about the task of presenting principles. But the problem with principles is that in real situations they often conflict. Principles develop because we value something; we view some aspect of life as so important that we want it protected. When we apply principles then we must be certain that we are actually protecting that original value in this specific situation. Principles must constantly be in dialogue with situations. This could very well mean that we may be discussing principles which may or may not actually apply in any particular case.

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Means of Caring for the Dying

There are four possible means of caring for the dying patient.

First, the physician and other caretakers consciously endeavor to make the period of terminal illness as happy and free from pain as possible, consistent with doing nothing that would hasten death - benemortasia.

Secondly, the physician in consultation with the family makes every effort to moderate discomfort, and thus condone jeopardizing the patients life in the process - mercy death.

Thirdly, the physician acknowledges his inability to heal the patient, ceases his therapy, and surrenders to superior biological forces - allowing to die.

Finally, the physician or some other health care professional actively participates in ending the life of a patient who pleads for release from the tribulations of incurable disease or the throes of dying. In the case of a patient in a persistent vegetative state, the family calls for the patient's release based upon their understanding of the person's desires - euthanasia.

I would like to examine each of these possibilities to determine which of them would be ethically acceptable and, if so, under what circumstances. Then I will place the issues of nutrition and hydration within these policies.

Voluntary Euthanasia Should Be Rejected

It should be noted, first of all that involuntary, active euthanasia is not even included as a possible category. The principle against taking an innocent life, the sacredness of life, and the respect for individual autonomy prevent the acceptance of crypthanasia (active euthanasia on sick people without their knowledge.)

I maintain that voluntary euthanasia be rejected as well. I don't want to belabor this point; euthanasia has been debated for twenty years. However, I would like to briefly support my contention. We now have some new insights into the issue as a result of the Dutch experience of the past few years. Writing in the Hastings Center Report, Dr. Richard Fenigsen presents the following arguments against Euthanasia based on his observations in his homeland.[1]

"Voluntary" euthanasia should be rejected because its voluntariness is often counterfeit and always questionable.

In this same article Dr. Fenigsen maintains that doctors in Holland have tried to coerce patients, and wives have coerced husbands and husbands wives to undergo "voluntary" euthanasia. Elderly people begin to consider themselves a burden to the society, and feel under an obligation to start conversations on euthanasia, or even to request it.

"Voluntary" euthanasia must be rejected because, contrary to the beliefs of some of its supporters, it is inseparable from, and inherently linked to overtly involuntary forms of euthanasia. When one form is acceptable, the

[1]Richard Fenigsen, "A Case Against Dutch Euthanasia," *Hastings Center Report*, Vol. 19 No. 1, (Jan-Feb 1989). pp. 22-30.

other is a foregone conclusion. It is inseparably linked to a changed attitude toward human life. Euthanasia revives repressed sadism and the spectre of the Nazi attitude which would eliminate life different from what is considered the norm.

In a recent book, H.W.A. Hilhorst, conducted a study in eight hospitals in Holland and discovered cases of involuntary active euthanasia on adults and children.[2]

Instead of the message a humane society sends to its members - "Everybody has the right to be around, we want to keep you with us, every one of you" - the society that embraces euthanasia, even the "mildest" and most "voluntary" forms of it, tells people: "We wouldn't mind getting rid of you." This message reaches not only the elderly and the sick, but all the weak and dependent.

"Voluntary" euthanasia should further be rejected because its promise is false. Euthanasia is supposed to spare the sick person the agony that precedes death or the sufferings of a prolonged illness. But this is not the case. When Wilbo van den Linden filmed one patient's preparations for voluntary euthanasia, about a million Dutch television viewers watched the unfortunate lady's anguish and despair as the fixed day of execution approached. The dying process causes enough uncertainty and fear that we need not add to the burden. Is it not better to die in hope, surrounded by cherished members of the family and human community who won't let us go? But euthanasia causes extreme psychological suffering -the excommunication, the exclusion of a person from the community of the living while still alive.

"Voluntary" euthanasia must also be rejected because of the fundamental discrepancy between the uncertainty of human (and medical) judgements, which are fallible, and the deadly certainty of the act.

Clinicians have traditionally rejected euthanasia because they realize that we all make mistakes, that diagnoses are uncertain and prognoses notoriously unreliable.

It was an unforgivable professional mistake and possibly a crime when an internist at a Rotterdam hospital decided to perform active, involuntary euthanasia because the patient was semi-conscious, overlooking the fact that this condition was caused by the tranquilizer he himself had prescribed.

"Voluntary" euthanasia is to be rejected because it is totally unnecessary.

One physician wrote: "In my many years of work as a hospital doctor, I attended thousands of patients and, much to my regret, many hundreds of them died. They needed support and relief from pain, breathlessness, or nausea. Until their last conscious moments they needed to belong, to share with all of us our common destiny, fears, uncertainties, and hopes. None of them needed euthanasia, and with a single exception in 36 years none of them asked for it. It is the most demanding task of the doctor to assist his patients to the very end."[3]

[2]*Ibid.* p. 24.
[3]*Ibid.* pp. 22-30.

Natural dying is not an ordeal and the body itself supports the relief of pain. The experience of many hospital chaplains shows it is often the neurotic patients suffering from mental, not physical, pain who ask to die.

"Voluntary" euthanasia should also be rejected because of the flaws in its philosophy. The concept of "quality of life," frequently used in the philosophy of euthanasia, implies an objective, impartial assessment. But in the words of C. Everett Koop, "Nothing in medicine enables one person to make a true judgement about another person's "quality of life."[4] Although as we will see later, I do believe it is possible to decide about "quality of life" once we clarify the meaning behind the phrase.

A common argument in today's society is that the individual has the absolute right to self-determination. But everyone rushes to help at the sight of a clothed person preparing to jump from a bridge into a river!

Euthanasia is advocated to alleviate the suffering of people whose lives are artificially prolonged by machines. But in Holland, most acts of euthanasia are performed by general practitioners at patient's homes, on patients treated without any special techniques. The assertion that the growing need for euthanasia is due to the proliferation of homes for the elderly, where the isolation and the meaninglessness of existence prompt people to request death is false. The homes for the elderly are not natural disasters - facts of life that we must resign ourselves to. These institutions are the result of our own conscious actions and many people are working to change their structures.

"Voluntary" euthanasia should be rejected and mistrusted because of the irreparable damage it causes to medicine. Curative medicine motivates a doctor to grasp and memorize a great number of facts relevant to the case, while euthanasia dispenses the doctor from this necessity, and it undermines the doctor-patient relationship. When we are sick we want Marcus Welby as our physician, but a euthanizing physician is inconsistent with this image. Patients will realize that doctors capable of putting them to death at their own request will also be capable of doing it without their consent.

My discussions with many of the elderly here in Florida leads me to conclude that the reason that euthanasia has become more acceptable is because of the actions of doctors themselves. One after another people have approached me after a talk, with stories of how a friend's or spouse's, life was prolonged needlessly. They fear the same will happen to them. Doctors are mistrusted because in their treatment of the disease, and in their zeal to overcome death, they have lost sight of the individual. At one time doctors realized that when their best efforts failed, the only appropriate care was the fluffing of a pillow, the washing of a brow, and the murmuring of familiar prayers.

What About Allowing Someone to Die?

Two questions first must be answered. (1) Which "hopelessly ill" patients, if any, should be allowed to die? What circumstances make it acceptable to

[4]C Everett Koop, "The Challenge of Definition," *Hastings Center Report*, Vol. 19 No. 1, (Jan-Feb 1989): 2-3.

allow someone to die, what criteria do we look for, and who will determine when it is just? (2) What difference is there between allowing someone to die and killing them?

What Constitutes Meaningful Life?

Without resorting to slogans - like the abortion debate - is there a point when life is not meaningful life?

The old standby in this issue used to be the distinction between ordinary and extraordinary means. It was stated by Pope Pius XII[5] and restated by both Catholic and Protestant moralists since.

Ordinary means are all medicines, treatments, and operations, which offer a reasonable hope of benefit and which can be obtained and used without excessive pain, or other inconvenience. Extraordinary means are all medicines, treatments and operations, which cannot be obtained or used without excessive expense, pain or other inconvenience, or which, if used, would not offer a reasonable hope of benefit. Daniel Maguire has greatly improved the definition by changing the expression "hope of benefit" to "hope of return to reasonable health." To administer antibiotics to a patient with pneumonia who is in the latter stages of bone cancer could produce some hope of benefit. There is not, however, hope of a return to health. Therefore, the use of antibiotics would be extraordinary and not morally necessary. To omit insulin under the same conditions would likewise be moral for the same reason. In the case of a person in a persistent vegetative state, intravenous feeding would be extraordinary.[6]

Even this new definition of Maguire is problematic. What constitutes "reasonable heath?" Physicians have always been uncomfortable with the distinction between ordinary and extraordinary means. Now they are asked to define health itself. The term "health" is obviously meant as a norm in this context and not as an ideal. A norm requires a baseline. What tool would a physician or concerned individual have for identifying such a baseline?

There is such a tool if we carefully analyze the value that we intend to protect. Richard McCormick gives us this analysis in his seminal essay, "To Live or Let Die: the Dilemma of Modern Medicine." Why is life valuable? Is it an end in itself?[7]

There exists a continuum from medical vitalism on one side, which preserves life at any cost - which is basically an idolatry of life - to medical pessimism on the other side which kills when life seems burdensome, frustrating, and useless.

Life is indeed a basic and precious good, but it is a good to be preserved as a condition of other values. Life is a relative good and the duty to preserve it is a limited one.

What are the values that life is a condition for? I am going to state McCormick's conclusion without presenting his proof - because of space -

[5]*AAS* 49 (1957) 1031-1032

[6]Daniel C. Maguire, *Death by Choice* (New York, 1984), p. 104.

[7]Richard A. McCormick, *How Brave A New World* (New York: Doubleday, 1981), pp. 339-351.

that life exists for the purpose of human relationships. The highest "good" of human life is the ability to enter into relationships of love.

When it requires so much time, energy, and resources just to keep a person alive, so that there is no possibility for the person to maintain relationships, then our responsibility to maintain that life should cease. Life's quality makes its preservation not worthwhile to the individual.

Maguire, in his book, *Death by Choice,* quotes a story of a teacher who annually took a class of senior students in psychology to visit the hospital ward in a training school for mental defectives.[8] (For the purposes of this article, however, the story has been altered slightly.) There was a little boy about 4 years old the first time we visited him in the hospital. He was a hydrocephalic with a head so immensely large that he had never been able to raise it off the pillow and never would. He had a tiny little body with this huge head. He also had a spinal bifida which made him partially paralyzed and it was difficult to keep him from developing sores. The students asked, "Why do we keep a child like that alive?"

The next year we went back with another class. The year the child's hands had been padded to keep him from hitting his head. The third year we went back and visited the same child. Now the nurses explained that he had been hitting his head so hard that in spite of the padding he was injuring it severely and they had tied his arms down to the sides of his crib. They also said that he had developed heart lesions and that surgery had been performed. There would be no reason for such surgery. This child had no possibility of meaningful relationships with others because of his mental condition. A Down's syndrome child would perhaps be a different story.

However, a person suffering from senile dementia is rather like a child (which makes their care so much difficult) but still capable of gratitude, simple pleasure and affection. The possibility of meaningful relationships still exists here, a distinguishable personal consciousness unlike someone, for instance in a persistent vegetative state. Furthermore, dementia is somewhat susceptible to remission and there can be moments of startling lucidity.

When the importance of relationships gets lost in the struggle for survival, it would be considered moral to suspend treatment.

It's like living up North in the winter. When the struggle to merely survive in the frozen stretches of January and February become unbearable some of us decided it's time to move to Florida.

This is what's behind the concept of extraordinary means—life is a value to be preserved only insofar as it contains some potentiality for human relationships. When this is not the case the best treatment becomes no treatment. It is not always easy to determine when this point occurs. Physicians must learn to give guidance in this area. There are four guidelines that the theologian Richard McCormick makes explicit: 1) one should always err on the side of life 2) life saving interventions ought not be omitted because of burdens they impose on the family or for institutional or managerial reasons. These groups are owed assistance by larger social bodies; 3) even relatively significant retardation alone is not adequate reason for nontreatment and 4)

[8]Maguire, p. 145.

life-sustaining interventions may be omitted in cases of excessive hardship for the patient, especially if combined with poor prognosis.[9]

Distinction Between Killing and Allowing to Die

The second question surrounds the distinction between killing and allowing to die. Some moralists, such as Michael Bayles argue that there is no moral difference between killing and allowing to die.[10] He would argue that throwing someone into a river is morally equivalent to not handing a life preserver to a drowning person when one is readily available. If, for instance, we would allow someone to die by not feeding them, Dick Westley says, that we merely lack the courage necessary to give a lethal injection.[11] Bayles and Westley both point out the intention is the same in both cases - the death of the individual.

In an article in the Hastings Center Report, Daniel Callahan presents the most cogent argument in favor of utilizing this distinction in moral cases to date. This distinction separates those deaths caused by human action, and those caused by nonhuman events. It is meant to say something about human beings and their relationship to the world. It articulates the difference between those actions for which human beings can be held rightly responsible, or blamed, and those of which they are innocent. It highlights the difference between physical causality, the realm of impersonal events, and moral culpability, the realm of human responsibility.[12]

Despite the criticisms - resting upon ambiguities that can readily be acknowledged - the distinction between killing and allowing to die remains, perfectly valid. This distinction is best understood as expressing three different, though overlapping perspectives. Callahan calls them the metaphysical, the moral, and the medical perspectives.

METAPHYSICAL. We should never forget that there is a sharp difference between the self and the external world. There is a world external to the self that has its own, and independent causal dynamism. The mistake behind a conflation of killing and allowing to die is to assume that the self has become master of everything within and outside the self. We can cure disease, but not always the chronic illness that comes with the cure. We can forestall death, but death always wins in the long run because of the limitations of the body beyond human control.

MORAL. At the center of the distinction between killing and allowing to die is the difference between physical causality and moral culpability. To bring the life of another to an end by an injection kills directly; our action is the physical cause of the death. To allow someone to die from a disease we

[9]McCormick, Richard A., "Notes on Moral Theology: 1983." *Theological Studies*, No. 45 (March 1984), pp. 80-138.

[10]Michael D. Bayles, "Euthanasia and the Quality of life" in *Medical Treatment of the Dying: Moral Issues*, eds. Michael D. Bayles and Dallas M. High. 1978, pp. 128-152.

[11]Dick Westley, *Morality and Its Beyond* (Mystic, Connecticut: Twenty-Third Publications, 1984), p. 240.

[12]Callahan, Daniel, "Can We Return Death to Disease?" *Hastings Center Report*, Vol 19 No. 1, (Jan-Feb 1989), pp. 4-5.

cannot cure (and that we did not cause) is to permit the disease to act as the cause of death. The notion of physical causality in both cases rests on the difference between human agency and the action of external nature. Ambiguity arises precisely because we can be morally culpable for killing someone (if we have no moral right to do so, as we would in self defense) and no less culpable for allowing someone to die (if we have both the possibility and the obligation of keeping that person alive). There are cases where, morally speaking; it makes no difference whether we kill or allow to die; we are equally responsible. In those instances the lines of physical causality and moral culpability happen to cross. But there are times when the obligation is precisely to allow the person to die.

MEDICAL. An important social purpose of the distinction between killing and allowing to die has been that of protecting the historical role of the physician. As we saw with euthanasia, the physician is the one who tries to cure or comfort patients rather than to kill. Yet, the physician is not always required to use his or her knowledge or power to keep people alive. The physician's ultimate responsibility is to the welfare of the patient, and excessive treatment can be as detrimental to that welfare as inadequate treatment.[13]

We need not spend much effort on an ethical analysis of benemortasia and mercy death. The intent of the heart is what is important. It certainly is acceptable to treat someone with all possible care if that is what they seek. In the words of Dr. Koop, "The intent behind gradual administration of drugs is to be her ally in her remaining hours or days of life and to keep her reasonably comfortable as she slips away."[14]

What About Removal of Feeding Tubes?

This brings us to the especially troublesome group of cases. What about those situations where a patient is unable to carry out an ordinary biological function (to eat on one's own) and the decision is to remove the artificial feeding tube? On the level of physical causality, have we killed the patient or allowed him to die? Because of the highly charged statement - we starved the patient to death - it seems unacceptable. In one sense it is our action that shortens his life, and yet in another sense his underlying disease brings his life to an end. I believe it is reasonable to say that his life is being sustained by artificial means made necessary by the fact of an incapacitating disease. Therefore, the disease is the ultimate reality behind his death. Except for the fact of the disease, there would be no need for artificial sustenance in the first place and then there is no moral issue at all.

Artificial feeding is different from ordinary feeding in that a patient may feel hunger and thirst even though tube feeding is adequate, or conversely may feel no hunger or thirst when in fact, the patient is malnourished. As such artificial feeding consists of a medical therapy which can and should be stopped when it doesn't help the overall welfare of the patient.

[13]*Ibid.*, p. 5
[14]Koop. p.3.

Moreover, death cannot be the direct intention of withdrawal of artificial feeding and therefore forbidden as suicide or murder, any more than omission of other medical treatments refused by or for critically ill patients. The moral evaluation depends on what a given treatment can be expected to do for a given patient.

The heart of the question of removal of tubes is the evaluation of benefits. Life in a persistent vegetative state cannot be construed as a benefit to the one in such a state. Instead, the interdependence between a person's biological condition and his or her ability to pursue life's goals of relationships must be considered. Forced feeding of the semi-conscious elderly, often against their own efforts to remove tubes can be dehumanizing.[15]

Conclusion

This article has outlined ethically appropriate care for the terminal patient, especially a patient in a persistent vegetative state whose life is prolonged by artificial nutrition. I have distilled for the reader the thinking of respected ethicists on this subject. Of the possible means of caring for the dying patient, voluntary or involuntary euthanasia alone has been rejected. McCormick, Maguire, and Callahan demonstrate that it is permissible to allow the progress of disease to claim a life when that life is consuming itself. Maguire would even allow some form of euthanasia. The essential insight is that just as life is lived in the midst of relationships, dying, too, is part of our relationships. Death, they say, is the great adversary. But this is not so. It is those who mute and mishandle us at the end. Death is inevitable. The other is not.

[15]Lisa Sowle Cahill, "On Richard McCormick," *Second Opinion*, Vol. 9 (November, 1988) p. 122.

Euthanasia

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Introduction

The word *euthanasia* is derived from the Greek *eu*, meaning "well, good, or pleasant," and *thanatos*, meaning "death." Webster's dictionary defines euthanasia as the mode or act of inducing death painlessly or as a relief from pain. The popular expression for euthanasia is mercy killing. Perusal of the medical literature of the last three decades reveals a host of books, articles, editorials, and letters to editors of journals dealing with this subject. These writings are exclusive of the legal, theologic, psychologic, and social literatures. Even the lay press is replete with writings on euthanasia, from the withholding of treatment from a handicapped newborn to the withdrawal of life-support systems from a terminally ill patient.

There is thus little doubt as to the tremendous interest in euthanasia. This chapter is an attempt to briefly review the subject by providing classification and terminology, citing selected examples, describing the legal attitude toward euthanasia in various countries, discussing the arguments put forth for and against euthanasia, briefly mentioning the Catholic and Protestant viewpoints on euthanasia, and finally presenting in detail the Jewish attitude toward euthanasia.

Classification and Terminology

A euphemistic term used by euthanasia societies for mercy killing is "merciful release"[1] or "liberating euthanasia."[2] Some people classify euthanasia into three types: eugenic, medical, and preventive.[3] A more meaningful classification speaks of eugenic, active medical, and passive medical euthanasia.[4] Eugenic euthanasia encompasses the "merciful release" of handi-

[1]E.E. Fibey, "Some Overtones of Euthanasia," *Hospital Topics* 43 (1965): 55 ff.

[2]C.P. Delhaye, "Euthanasie ou mort par pitié," *Union Médicale de Canada* 90 (1961): 613 ff.

[3]J. Crinquette. "L'euthanasie," *Journale de Sciences Médicales de Lille* 81 (1963): 522 ff.

[4]Fibey, op. cit.

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capped newborns and socially undesirable individuals, such as the mentally retarded and psychiatrically disturbed. Perhaps an extreme example of this method of extermination was the Nazi killing of all the socially unacceptable or socially unfit, including Jews. To many, this German practice as well as all eugenic euthanasia is considered nothing less than murder; there are very few proponents of this type of euthanasia.

Active medical euthanasia is exemplified by the case where a drug or other treatment is administered, and death is thereby hastened. This type of euthanasia may be voluntary or involuntary, that is, with or without the patient's consent.

Passive medical euthanasia is defined as the situation in which therapy is withheld so that death is hastened by omission of treatment. This type of euthanasia has also been called automathanasia,[5] meaning automatic death, such as without therapeutic heroics. This passive form of euthanasia can also be voluntary or involuntary.

Exemplification of the Problem

Many a physician has had to wrestle with the problem of an incurably ill, suffering patient. Such physicians fully realize that "whereas life is lengthened, a man's period of usefulness is not always lengthened."[6] Some are of the opinion that advanced medicine should "serve only to improve the condition of human life as it increases the life span and not the useless prolongation of human suffering."[7] Thus, a general practitioner in Manchester, New Hampshire, ended a cancer patient's suffering by injecting into the patient a substantial quantity of air intravenously. He was acquitted.[8] A Stamford, Connecticut, woman shot and killed her father who was dying of incurable cancer. She was acquitted.[9]

The problem is far from localized to the shores of the United States. Giuseppe F., having settled in France, was struck with an incurable disease. He summoned his brother Luigi and convinced the latter to kill him, which Luigi did. The jury acquitted Luigi.[10]

One of the most famous instances exemplifying many of the problems surrounding euthanasia is the case of the physician son of the founder of the British Euthanasia Society, who told a Rotary meeting: "To keep her from pain . . . I gave her an injection to make her sleep."[11] His objective, as specifically stated, was to relieve pain, not to put an end to the patient's life. An outcry in the British press followed, labeling the incident "a mercy kill-

[5]F. Monnerot-Dumaine, "Les notions d'euthanasie et d'automathanasie," *Presse Médicale* 72 (1964): 1458.

[6]A.A. Levisohn, "Voluntary Mercy Deaths: Sociolegal Aspects of Euthanasia," *Journal of Forensic Medicine* 8 (1961): 57 ff.

[7]Ibid.

[8]Delhaye, op. cit.

[9]Ibid.

[10]P.R. Archambault, "Le probléme d'euthanasie considerée par un médecin Catholique," *Union Médicale de Canada* 91 (1962): 543 ff.

[11]Levisohn, op. cit.

ing." Even the British Euthanasia Society admitted that from a strictly legal sense mercy killing is murder, but it backed the physician by insisting that "every doctor must be guided by his own conscience." Many physicians disagreed, saying euthanasia is legalized murder. Others cited the Hippocratic oath, which states: "I will give no deadly medicine to anyone if asked, nor suggest any such counsel." Still others were of the opinion that the Hippocratic oath refers only to premeditated murder. The medical council refused to act against the physician unless the family of the deceased lodged a formal complaint. However, the family consented to the physician's actions. Thus, all the ingredients to emphasize the problem of euthanasia are present in this case: the incurable patient in great pain, the request for euthanasia by patient and family, and the physician's acquiescence and participation.

The list of examples one could cite is endless. The aforementioned illustrative cases serve as background for the ensuing discussion.

Legal Considerations

Although suicide is not legally a crime in most American jurisdictions, aiding and abetting suicide is a felony. Euthanasia, even at the patients request, is legally murder in the United States. In England the Suicide Act of 1961 states that it is not a criminal offense for a person, whether in sickness or in health, to take his own life or to attempt to do so. However, any individual who helps him to do so become liable to a charge of manslaughter. Euthanasia *per se* does not exist in the law books of France and Belgium, and in both countries it is considered premeditated homicide. However, a bill to legalize euthanasia for some "damaged" children came before the Belgian government following the famous Liége trial involving parents, relatives, and a physician charged with murdering a thalidomide-damaged child.[12]

In Italy, euthanasia is only a crime if the victim is under eighteen years of age, mentally retarded, or menaced or under the effect of fear. More tolerant attitudes also exist in Denmark, Holland, Yugoslavia, and even Catholic Spain. In the Soviet Union, euthanasia is considered "murder under extenuating circumstances" and punishable with three to eight years in prison.[13] Switzerland seems to have the most lenient legislation.[14] Ths Swiss penal code, as revamped in 1951, distinguishes between killing with bad intentions, that is, murder, and killing with good intentions, that is, euthanasia. In addition, in 1964 in Sweden, passive euthanasia was legalized. Even in countries where euthanasia is legally murder, "the sympathies of juries towards mercy killings often cause the law to be circumvented by various methods, making for great inequities of the legal system.[15]

In 1935 the first Euthanasia Soceity was founded in England for the purpose of promoting legislation which would seek to "make the act of dying

[12]L. Colebrook, "The Liége Trial and the Problem of Voluntary Euthanasia," *Lancet* 2 (1962): 1225.

[13]Delhaye, op. cit.

[14]Crinquette, op. cit.

[15]G.A. Friedman, "Suicide, Euthanasia and the Law," *Medical Times* 85 (1957): 681 ff.

more gentle." In 1936, one year after the founding of the society, a bill was introduced into the House of Lords which sought to permit voluntary euthanasia in certain circumstances and with certain safeguards. Following a rather heated debate, it was decided that "in view of the emergence of so many controversial issues, it would be best to leave the matter for the time being to the discretion of individual medical men . . . the bill was rejected by 35 votes to 14."[16]

Three years after the inception of the British group, the Euthanasia Society of America, Inc., was founded. This nonsectarian, voluntary organization, rather than seeking to have legislation enacted to legalize euthanasia, attempts to achieve a more enlightened public understanding of euthanasia through dissemination of information through discussions in medical societies and other professional groups, research studies and opinion polls, dissemination of literature, a speaker's bureau, and other responsible media of communication.

Other euthanasia societies have been founded in other countries. Support for these societies and their work comes from various other groups, such as the American Humanist Association and the Ethical Culture Society. Opposition to euthanasia is also strong, however. The Academy of Moral and Political Sciences of Paris passed a motion completely outlawing, forbidding, and rejecting euthanasia in all its forms.[17] In addition, the Council of the World Medical Association, meeting in Copenhagen in April 1950, recommended that the practice of euthanasia be condemned.

The debate continues. The problem has been well stated by Fibey: "When a tortured man asks: 'For God's sake, doctor, let me die, just put me to sleep,' we have yet to find the answer as to whether to comply is for God's sake, the patient's sake, our own, or possibly all three."[18] Even if the moral issue of euthanasia could be circumvented, other questions of logistics would immediately arise: Who is to initiate euthanasia proceedings? The patient? The family? The physician? Who is to make the final decision? The physician? A group of physicians? The courts? Who is to carry out the decision if it is affirmative? The physician? Others?

Arguments For and Against

The arguments in favor of and against euthanasia are numerous and will only be briefly summarized. Opponents of euthanasia say that if voluntary, it is suicide. Although in British law suicide is no longer a crime, Christian and Jewish religious teachings certainly outlaw suicide. The answer offered to this argument is that martyrdom, a form of suicide, is condoned under certain conditions. However, the martyr primarily seeks not to end his life but to accomplish a goal, death being an undesired side product. Thus martyrdom and suicide do not seem comparable.

It is also said that euthanasia, if voluntary, is murder. Murder, however, usually connotes premeditated evil. The motives of the person admini-

[16]*A Plan for Voluntary Euthanasia* (London: Euthanasia Society, 1962), p. 28.
[17]Delhaye, op. cit.
[18]Fibey, op. cit.

stering euthanasia are far from evil. On the contrary, such motives are commendable and praiseworthy, although the methods may be unacceptable. A closely related objection to euthanasia says that it transgresses the biblical injunction *Thou shalt not kill.*[19] To overcome this argument, some modern biblical translators substitute "Thou shalt not commit murder," and, as just mentioned, murder usually represents violent killing for purposes of gain or treachery or vendetta and is dissimilar to the "merciful release" of euthanasia.

That God alone gives and takes life[20] and that one's life span is divinely predetermined is not denied by the proponents of euthanasia. The difficulty with this point, seems to be the question of definition as to whether euthanasia represents shortening of life or shortening of the act of dying.

It is also said that suffering is part of the Divine plan, with which man has no right to tamper. This phase of faith remains a mystery and is best exemplified by the story of Job.

It is further argued by opponents of euthanasia that since physicians are only human beings, they are liable to error. There is no infallibility in a physician's diagnosis of an incurably ill patient, and mistakes have been made. They may be exceedingly rare, but they do occur. The same is true of spontaneous remission of cancer: it has been reported, but only in rare instances.

The need for euthanasia today is minimized by some because of the availability of hypnotics, narcotics, anesthetics, and other analgesic means to keep a patient's pain and distress at a tolerable level. This fact, in general, may be true, but occasional patients develop severe pain which is refractory to all drugs and requires surgical interruption of nerve pathways for relief.

The Hippocratic oath or similar vow which physicians take upon graduation from medical school is conflicting. On the one hand, it states that a physician's duty is to relieve suffering, yet on the other hand, it also states that the physician must preserve and protect life. The oath is used as an argument by both proponents and opponents of euthanasia.

A valid point of debate is the suggestion that if euthanasia for incurably ill, suffering cancer patients were legalized, extension of such legislation to handicapped, deformed, psychotic, or senile patients might follow. An editorial states: "If euthanasia is granted to the first class, can it long be denied to the second? . . . Each step is so short; the slope so slippery, our values in this age, so uncertain and unstable. . ."[21]

Further questions are the sincerity of patients and/or family in requesting euthanasia. A patient racked with pain may make an impulsive but ill-considered request for merciful release which he will not be able to retract or regret after the *fait accompli.* The patient's family may not be completely sincere in its desire to relieve the patient's suffering. The family also wishes to relieve its own suffering. Enemies or heirs of the patient may request hastening of the patient's death for ulterior motives. These and further arguments both for and against euthanasia continue to be discussed and debated.

[19]Exodus 20:13 and Deuteronomy 5:17.

[20]See Deuteronomy 32:39, *I kill and I make alive*, and Ezekiel 18:4. *Behold, all souls are Mine.*

[21]Editorial, "Euthanasia," *Lancet* 2 (1961): 351.

Catholic Attitude

In at least five places the New Testament contains the biblical admonition *Thou shalt not kill*.[22] Based thereon, the attitude of the Catholic church in this matter is cited as follows:

> The teaching of the Church is unequivocal that God is the supreme master of life and death and that no human being is allowed to usurp His dominion so as deliberately to put an end to life, either his own or any one else's without authorization . . . and the only authorizations the Church recognizes are a nation engaged in war, execution of criminals by a Government, killing in self defense. . . . The Church has never allowed and never will allow the killing of individuals on grounds of private expediency; for instance . . . putting an end to prolonged suffering or hopeless sickness.[23]

Thus we see a blanket condemnation of active euthanasia by the Catholic church as murder and, therefore, a mortal sin. The reasons behind this teaching include the inviolability of human life, or the supreme dominion of God over His creatures, and the purposefulness of human suffering.[24] Man suffers as penance for his sins, perhaps an earthly purgatory; man endures pain for the spiritual good of his fellowman, and suffering teaches humility.

Passive medical euthanasia is treated quite differently. The church distinguishes between "ordinary" and "extraordinary" measures employed by physicians when certain death and suffering lie ahead. In this day of artificial and auxiliary hearts, artificial kidneys, respirators, pacemakers, defibrillators, and similar instruments, the definition of "extraordinary" is unclear. Pope Pius XII issued an encyclical not requiring physicians to use heroic measures in such circumstances.[25] Thus, passive euthanasia seems to be sanctioned by the Catholic church. In an address to the congress of Italian anesthetists on February 24, 1957, the Pope further stated: "Even if narcotics may shorten life while they relieve pain, it is permissible."[26]

Protestant Attitude

In the Protestant churches there are "all possible colors in the spectrum of attitudes toward euthanasia."[27] Some condemn it, some favor it, and many are in between, advocating judgment of each case individually. Perhaps the greatest Protestant advocate of legalized euthanasia is the Anglican minister Joseph Fletcher. His three main reasons are the following: (a) suffering is purposeless, demoralizing, and degrading; (b) human personality is of greater worth than life *per se*; and (c) the New Testament phrase "Blessed are the

[22]Matthew 5:21 and 19:18, Mark 10:19, Luke 18:20, and Romans 13:9.

[23]I.M. Rabinowitch and H.E. McDermot, "Euthanasia," *McGill Medical Journal* 19 (1950): 160 ff.

[24]E.F. Torrey, "Euthanasia: A Problem in Medical Ethics," *McGill Medical Journal* 30 (1961): 127 ff.

[25]Archambault, op. cit.; J.H. McClanahan, "The Patient's Right to Die: Moral and Spiritual Aspects of Euthanasia," *Memphis Medical Journal* 38 (1963): 303 ff.

[26]Archambault, op. cit.

[27]Torrey, op. cit.

merciful, for they shall obtain mercy" is as important as the biblical *Thou shalt not kill.*

Jewish Attitude

Biblical Sources

In the Bible we find: *Whoso sheddeth man's blood, by man shall his blood be shed.*[28] In the second book of the Pentateuch it is stated: *Thou shalt not murder,*[29] and in the next chapter, *And if a man come presumptuously upon his neighbor, to slay him with guile: thou shalt take him from Mine altar that he may die.*[30] In the next book is the phrase *And he that smiteth any man mortally shall surely be put to death,*[31] and four sentences later, *And he that killeth a man shall be put to death.*[32] In Numbers it states: *Whoso killeth any person, the murderer shall be slain at the mouth of witnesses.*[33] Finally, the sixth commandment of the Decalogue is repeated: *Thou shalt not murder.*[34] Thus, in every book of the Pentateuch, we find at least one reference to murder or killing. Accidental death or homicide is dealt with separately in the Bible and represents another subject entirely.

Probably the first recorded instance of euthanasia concerns the death of King Saul in the year 1013 B.C.E. At the end of the First Book of Samuel, we find the following:

> Now the Philistines fought against Israel, and the men of Israel fled from before the Philistines and fell down slain in Mount Gilboa. The Philistines pursued hard upon Saul and upon his sons; and the Philistines slew Jonathan and Abinadab and Malchishua, the sons of Saul. And the battle went sore against Saul, and the archers overtook him, and he was greatly afraid by reason of the archers. Then said Saul to his armor-bearer: "Draw thy sword, and thrust me through therewith, lest these uncircumsised come and thrust me through and make a mock of me." But his armor-bearer would not; for he was sore afraid. Therefore, Saul took his sword and fell upon it. And when the armor-bearer saw that Saul was dead, he likewise fell upon his sword and died with him. So Saul died and his three sons, and his armor-bearer, and all his men, that same day together.[35]

From this passage it would appear as if Saul committed suicide. However, at the beginning of the Second Book of Samuel, when David is informed of Saul's death, we find the following:

> And David said unto the young man that told him: "How knowest thou that Saul and Jonathan his son are dead?" And the young man that told him said: "As I happened by chance upon Mount Gilboa, behold, Saul leaned upon his spear; and lo, the chariots and the horsemen pressed hard upon him. And when he looked behind him, he saw me, and called unto me. And I answered: Here am

[28]Genesis 9:6.
[29]Exodus 20:13.
[30]Ibid. 21:14.
[31]Leviticus 24:17.
[32]Ibid. 24:21
[33]Numbers 35:30.
[34]Deuteronomy 5:17.
[35]I Samuel 31:1-6.

I. And he said unto me: Who art thou? And I answered him: I am an Amalekite. And he said unto me: Stand, I pray thee, beside me, and slay me, for the agony hath taken hold of me; because my life is just yet in me. So I stood beside him, and slew him, because I was sure that he would not live after that he was fallen. . ."[36]

Many commentators consider this a case of euthanasia. Rabbi David Kimchi (*Radak*) specifically states that Saul did not die immediately on falling on his sword but was mortally wounded and in his death throes asked the Amalekite to hasten his death. Rabbi Levi ben Gerson (*Ralbag*), Rabbi Shlomo ben Isaac (*Rashi*), and Rabbi David Altschul (*Metzudat David*) also support this viewpoint. Some modern scholars think that the story of the Amalekite was a complete fabrication.

Talmudic Sources

The Taimud states as follows: "One who is in a dying condition (*goses*) is regarded as a living person in all respects."[37] This rule is reiterated by the codifiers of Jewish law, including Maimonides and Karo, as described below. The Talmud continues.[38]

One may not bind his jaws, nor stop up his openings, nor place a metallic vessel or any cooling object on his navel until such time that he dies, as it is written: *Before the silver cord is snapped asunder.*[39]

One may not move his, nor may one place him on sand or on salt until he dies.

One may not close the eyes of the dying person. He who touches them or moves them is shedding blood because Rabbi Meir used to say: This can be compared to a flickering flame. As soon as a person touches it, it becomes extinguished. So too, whosoever closes the eyes of the dying is considered to have taken his soul.

Other laws pertaining to a *goses*, or dying person, such as the preparation of a coffin, inheritance, marriage, and so forth, are then cited.

The Talmud also mentions: "He who closes the eyes of a dying person while the soul is departing is a murderer [lit. he sheds blood]. This may be compared to a lamp that is going out. If a man places his finger upon it, it is immediately extinguished."[40] *Rashi* explains that this small effort of closing the eyes may slightly hasten death.

The most famous talmudic passage concerning euthanasia is the story of Rabbi Chanina ben Teradion, who was wrapped by the Romans in a Scroll of the law (Torah), with bundles of straw around him which were set on fire.[41] The Romans also put tufts of wool which had been soaked in water over his heart so that he should not die quickly. His disciples pleaded with him to open his mouth "so that the fire enter into thee" and put an end to his

[36]II Samuel 1:5-10

[37]Semachot 1:1.

[38]Ibid. 1:2—4.

[39]Ecclesiastes 12:6. The Midrash interprets the silver cord to refer to the spinal cord.

[40]Shabbat 151b.

[41]Avodah Zarah 18a.

agony. He replied: "Let Him who gave me [my soul] take it away" but no one is allowed to injure himself or hasten his death.

Codes of Jewish Law

The twelfth-century code of Maimonides treats our subject matter as follows:

> One who is in a dying condition is regarded as a living person in all respects. It is not permitted to bind his jaws, to stop up the organs of the lower extremities, or to place metallic or cooling vessels upon his navel in order to prevent swelling. He is not to be rubbed or washed, nor is sand or salt to be put upon him until he expires. He who touches him is guilty of shedding blood. To what may he be compared? To a flickering flame, which is extinguished as soon as one touches it. Whoever closes the eyes of the dying while the soul is about to depart is shedding blood. One should wait a while; perhaps he is only in a swoon.[42]

Thus, we again note the prohibition of doing anything that might hasten death. Maimonides does not specifically forbid moving such a patient, as does the Talmud, but such a prohibition is implied in Maimonides' text. Maimonides also forbids rubbing and washing a dying person, acts which are not mentioned in the Talmud. Finally, Maimonides raises the problem of the recognition of death, a problem becoming more pronounced as scientific medicine improves the methods for supporting respiration and heart function.

The sixteenth-century code of Rabbi Joseph Karo devotes an entire chapter to the laws of the dying patient.[43] The individual in whom death is imminent is referred to as a *goses*. Karo's code begins, as do Maimonides and the Talmud, with the phrase "A *goses* is considered as a living person in all respects," and then Karo enumerates various acts that are prohibited. All the commentaries use the concept "lest they hasten the patient's death" to explain these prohibitions. One of the forbidden acts not mentioned by Maimonides or the Talmud is the removal of the pillow from beneath the patient's head. This act had already been prohibited two centuries earlier by Rabbi Jacob ben Asher, known as *Tur*.[44] Karo's text is nearly identical to that of *Tur*. The latter, however, has the additional general explanation: "the rule in this matter is that any act performed in relation to death should not be carried out until the soul has departed." Thus, not only are physical acts on the patient, such as those described above, forbidden, but one should also not provide a coffin or prepare a grave or make other funeral or related arrangements lest the patient hear of this and his death be hastened. Even psychological stress is prohibited.

On the other hand, thirteenth-century Rabbi Judah ben Samuel the Pious states: "if a person is dying and someone near his house is chopping wood, so that the soul cannot depart, then one should remove the [wood] chopper from there.[45]

Based on this ruling, Rabbi Moses Isserles, known as *Rema*, in his famous gloss on Karo's code, asserts:

[42]Maimonides, *Mishneh Torah, Hilchot Avel* 4:5.
[43]Karo, *Shulchan Aruch, Yoreh Deah* 339.
[44]*Tur, Yoreh Deah* 339.
[45]Judah the Pious, *Sefer Chasidim* no. 723.

> If there is anything which causes a hindrance to the departure of the soul, such as the presence near the patient's house of a knocking noise, such as wood chopping, or if there is salt on the patient's tongue, and these hinder the soul's departure, it is permissible to remove them from there because there is no act involved in this at all but only the removal of the impediment.[46]

Furthermore, Rabbi Solomon Eger, in his commentary on Karo's code,[47] quotes another rabbinic authority, who states "it is forbidden to hinder the departure of the soul by the use of medicines."[48] Other rabbinic authorities, however, disagree with the latter view.[49] Rabbi Joshua Boaz Baruch, known as *Shiltei Gibborim,* pleads for the abolition of the custom of those who remove the pillow from beneath the dying person's head, following the popular belief that the bird feathers contained in the pillow prevent the soul from departing.[50] He further states that Rabbi Nathan of Igra specifically permitted this act. *Shiltei Gibborim* continues: "After many years I found in the *Sefer Chasidim* support for my contentions, as it is written there that if a person is dying but cannot die until he is put in a different place, he should not be moved."[51] This law is not contradictory to the earlier statement in the *Sefer Chasidim*, as both *Shiltei Gibborim* and *Rema* explain: To do an act which prevents death, such as chopping wood, is forbidden, and on the contrary, such impediments to death should be removed. On the other hand, it is definitely forbidden to perform any act which hastens death, such as moving the dying person from one place to another.

Recent Rabbinic Rulings

This discussion of the Jewish attitude toward euthanasia is summarized by Jakobovits, who states that

> any form of active euthanasia is strictly prohibited and condemned as plain murder . . . anyone who kills a dying person is liable to the death penalty as a common murderer. At the same time, Jewish law sanctions the withdrawal of any factor—whether extraneous to the patient himself or not—which may artificially delay his demise in the final phase.[52]

Jakobovits is quick to point out, however, that all the Jewish sources refer to an individual called a *goses* in whom death is imminent, three days or less in rabbinic references. Thus, passive euthanasia in a patient who may yet live for weeks or months is not condoned. Furthermore, in the case of an incurably ill person in severe pain, agony, or distress, the removal of an impediment which hinders his soul's departure, although permitted in Jewish law, as stated by *Rema,* may not be analogous to the withholding of medical therapy that is perhaps sustaining the patient's life unnaturally. The impedi-

[46]*Rema on Shulchan Aruch, Yoreh Deah* 339:1.

[47]Eger, Commentary *Gilyon Maharsha* on *Shulchan Aruch, Yoreh Deah* 339:1.

[48]Jacob ben Samuel, Responsa *Bet Yaakov*, no. 59.

[49]J. Reishcer, Responsa *Shevut Yaakov,* pt. 3, no. 13.

[50]Baruch, Commentary *Shiltei Gibborim* on Moed Katan, end of chap. 3.

[51]See Judah the Pious, op. cit.

[52]I. Jakobovits, "The Dying and Their Treatment in Jewish Law: Preparation for Death and Euthanasia," *Hebrew Medical Journal* 2 (1961): 251 ff. See also idem, *Jewish Medical Ethics* (New York: Bloch, 1959), pp. 123-125.

ments spoken of in the codes of Jewish law, whether far removed from the patient, as exemplified by the noise of wood chopping, or in physical contact with him, such as the case of salt on the patient's tongue, do not constitute any part of the therapeutic armamentarium employed in the medical management of the patient. For this reason, such impediments may be removed. However, the discontinuation of life-support systems which are specifically designed and utilized in the treatment of incurably ill patients might only be permissible if one is certain that in doing so one is shortening the act of dying and not interrupting life.

Rabbi Eliezer Yehudah Waldenberg reiterates that physicians and others are obligated to do everything possible to save the life of a dying patient, even if the patient will only live for a brief period, and even if the patient is suffering greatly.[53] Any action that results in hastening of the death of a dying patient is forbidden and considered an act of murder. Even if the patient is beyond cure and is suffering greatly and requests that his death be hastened, one may not do so or advise the patient to do so.[54] A terminally ill incurable patient, continues Waldenberg, may be given oral or parenteral narcotics or other powerful analgesics to relieve his pain and suffering, even at the risk of depressing his respiratory center and hastening his death, provided the medications are prescribed solely for pain relief and not to hasten death.[55] Waldenberg also states that it is not considered interference with the Divine will to place a patient on a respirator or other life-support system.[56] On the contrary, all attempts must be made to prolong and preserve the life of a patient who has a potentially curable disease or reversible condition.[57] Thus, one must attempt resuscitation on a drowning victim who has no spontaneous respiration or heartbeat because of the possibility of resuscitation and reversibility.[58] One is not obligated or even permitted, however, to initiate artificial life support and/or other resuscitative efforts if it is obvious that the patient is terminally and incurably and irreversibly ill with no chance of recovery. One is also allowed to disconnect and discontinue life-support instrumentation, according to Waldenberg[59] and others, if one can establish that the patient is dead according to Jewish legal criteria,[60] that is, if the patient has no independent brain function or spontaneous cardiorespiratory activity.[61] If it is not clear whether the respirator is keeping the patient alive or only ventilating a corpse, the respirator must be maintained. It may not be turned off to test whether the patient has spontaneous respiratory activity because that small act may be the one that causes the patient's death, similar to the flickering lamp which may be extinguished if someone touches it (see above). Therefore, from a practical standpoint, Waldenberg advises that one

[53]Waldenberg, Responsa *Tzitz Eliezer*, vol. 5, *Ramat Rachel*, no. 28:5.
[54]Ibid., no. 29, and vol. 10, no. 25:6.
[55]Ibid., vol. 13, no. 87.
[56]Ibid., vol. 15, no. 37.
[57]Ibid., vol. 13, no. 89.
[58]Ibid., vol. 14, no. 81.
[59]Ibid., vol. 13, no. 89.
[60]Ibid., vol. 9, no. 46, and vol. 10, no. 25:4.
[61]See below, chap. 18.

use respirators with automatic time clocks set for a twelve or twenty-four hour period.[62] When the respirator shuts itself off, one can observe the patient for signs of spontaneous respiration. If none are present and if the heart is not beating and the brain is irreversibly damaged, one does not reconnect the respirator. Finally, Rabbi Waldenberg asserts that blood transfusions, oxygen, antibiotics, intravenous fluids, oral and parenteral nutrition, and pain-relief medications must be maintained for a terminally ill patient till the very end.[63]

Rabbi Shlomo Zalman Auerbach also states that a terminally ill patient must be given food and oxygen even against his will.[64] However, one may withhold, at the patient's request, medications and treatments which might cause him great pain and discomfort. Rabbi Gedaliah Aharon Rabinowitz reviews the laws pertaining to the care of the terminally ill and the criteria for defining the moment of death.[65] He also states that experimental chemotherapy for cancer patients is permissible but not obligatory.[66] Such therapy must have a rational scientific basis and be administered by expert physicians. Untested and unproven remedies may not be used on human beings. Dr. A. Sofer Abraham quotes Rabbi Auerbach as distinguishing between routine and nonroutine treatments for the terminally ill.[67] For example, a dying cancer patient must be given food, oxygen, antibiotics, insulin, and the like, but does not have to be given painful and toxic chemotherapy which offers no chance of cure but at best temporary palliation. Such a patient may be given morphine for pain even if it depresses his respiration. An irreversibly ill terminal patient whose spontaneous heartbeat and breathing stops does not have to be resuscitated.

Rabbi Moshe Hershler opines that withholding food or medication from a terminally ill patient so that he dies is murder.[68] Withholding respiratory support is equivalent to withholding food, since it will shorten the patient's life. Every moment of life is precious, and all measures must be taken to preserve even a few moments of life. However, if the physicians feel that a comatose patient's situation is hopeless, they are not obligated to institute life-prolonging or resuscitative treatments.

Hershler also states that if only one respirator is available and two or more patients need it, the physicians should decide which patient has the best chance of recovery. However, a respirator may not be removed from a patient who is connected thereto for another, even more needy patient, since one is prohibited from sacrificing one life to save another. Only it the patient has no spontaneous movement, reflexes, heartbeat, and respiration can the respirator be removed.

Rabbi Zalman Nechemiah Goldberg discusses the question of whether or not a physician may leave a dying patient to attend another patient.[69]

[62]Waldenberg, op. cit., vol. 13, no. 89.
[63]Ibid., vol. 14, no. 80.
[64]S. Z. Auerbach, in *Halachah Urefuah* 2 (1981): 131.
[65]G.A. Rabinowitz, in *Halachah Urefuah* 3 (1983): 102-114.
[66]Ibid., pp. 115-118.
[67]A.S. Abraham, in *Halachan Urefuah* 2 (1981): 185-190.
[68]M. Hershler, in *Halachah Urefuah* 2 (1981): 30-52.
[69]Z.N. Goldberg, in *Halachah Urefuah* 2 (1981): 191-195.

Rabbi Avigdor Nebenzahl describes the permissible use of narcotics for terminally ill patients.[70] The treatment of the terminally ill and the definition of a *goses* are reviewed by Levy and Abraham.[71] Rabbi Nathan Friedman reiterates that euthanasia in any form is prohibited as an act of murder even if the patient asks for it.[72] A person is prohibited from taking his own life even if he is in severe pain and suffering greatly.[73] Even if the patient cries out, "Leave me be and do not help me because I prefer death," everything possible must be done for the support and comfort of the patient, including the use of large doses of pain relief medications.[74]

Rabbi J. David Bleich affirms that although euthanasia in any form is forbidden, and the hastening of death, even by a matter of moments, is regarded as tantamount to murder, there is one situation in which treatment may be withheld from the moribund patient in order to provide for an unimpeded death.[75] While the death of a *goses* may not be hastened, there is no obligation to perform any action which might lengthen the life of such a patient. Bleich emphasizes, however, that "the distinction between an active and a passive act applies to a *goses* and a *goses* only." Among the criteria which indicate that the patient has become terminally ill and can be classified as a *goses* is the observation that he has the death rattle in his throat, probably representing "secretions in his throat on account of the narrowing of his chest."[76] Bleich cites some authorities who not only sanction withholding of treatment but prohibit any action which may prolong the agony of a *goses*. Other authorities insist that the life of a *goses* may not be shortened even passively by withdrawal of medication. Even the permissive rulings only sanction acts of omission for a *goses* in whom death is expected in less than seventy-two hours but not for a terminally ill patient who may yet survive weeks or months.

Conclusion

Bleich has succinctly summarized the Jewish attitude toward euthanasia.

> The practice of euthanasia—whether active or passive—is contrary to the teachings of Judaism. Any positive act designed to hasten the death of the patient is equated with murder in Jewish law, even if the death is hastened only by a matter of moments. No matter how laudable the intentions of the person performing an act of mercy-killing may be, his deed constitutes an act of homicide. . . .
>
> In discharging his responsibility with regard to prolongation of life, the physician must make use of any medical resources which are available. However,

[70]A. Nebenzahl, "The Use of Narcotics for Terminally Ill Patients," *Assia* 4 (1983): 260-262.

[71]Y. Levy, in *Noam* 16 (1973): 53-63; A. S. Abraham, "Treatment of the Terminally Ill (*Goses*) and the Determination of Death." *Assia* 3 (1983): 467-473.

[72]N. Friedman, Responsa *Netzer Matta'ai*, no. 30.

[73]Asher ben Yechiel, known as *Rosh*, Responsa *Besamim Rosh*, no. 348; M. Schreiber, Responsa *Chatam Sofer*, *Even Ha'ezer*, pt. 1 no. 69. See also below, chap. 17.

[74]Waldenberg, op. cit., vol. 9, no. 47:5.

[75]J. D. Bleich, *Judaism* and *Healing* (New York: Ktav, 1981), pp. 134-145.

[76]M. Isserles, Commentary *Rema* on Karo's *Shulchan Aruch*, *Even Ha'ezer* 121:7 and *Choshen Mishpat* 211:2 Bleich also refers the reader to Maimonides' (*Rambam*) and Yom Tov Lippman Heller's (*Tosafot Yom Tov*) commentaries on Arachin 1:3.

he is not obligated to employ procedures which are themselves hazardous in nature and may potentially foreshorten the life of the patient. Nor is either the physician or the patient obligated to employ a therapy which is experimental in nature.

. . . The attempt to sustain life, by whatever means, is naught but the expression of the highest regard for the precious nature of the gift of life and of the dignity in which it is held.

. . . Only the Creator, who bestows the gift of life, may relieve man of that life, even when it has become a burden rather than a blessing.[77]

Since the decisions about withholding specific therapy for a terminally ill patient, about the discontinuation of life-support systems, about whether or not to employ resuscitative measures in a given situation are complex and not free of family and/or physician personal and emotional involvement and even bias, it seems advisable to consult with a competent rabbinic authority for adjudication on a case-by-case basis.

[77]Bleich, op. cit.

The Right to Die, Nancy Cruzan, and the Importance of Advanced Directives

David M. DeDonato

One day I received a telephone call from one physician-patient of my wife's co-workers who knew that I taught health care ethics. He related that his uncle, a well established and successful attorney, had suffered a stroke a month before as the result of a myocardial infarction and was admitted to a local civilian hospital. The attending physician felt that the stroke was not serious and *Coumadin*, an anticoagulant, was given to the patient to reduce the risk of blood clots that precipitated the stroke.

Three days into the therapy, a blood clot was dislodged in a major blood vessel, with severe damage to the patient's brain function. After several weeks, the patient was diagnosed as being in a persistent vegetative state (PVS) with no hope of returning to a cognitive state. A feeding tube had been inserted and no other life-sustaining means was employed.

After consulting with the nephew, the only next-of-kin, the attending physician agreed to write a do-not-resuscitate order to withhold CPR should the patient experience cardiac or respiratory arrest. However, he refused to withdraw the feeding tube because it was contrary to hospital policy to do so unless the patient was either brain dead or had indicated his wishes in a Directive to Physicians, commonly referred to as a Living Will. The patient was not brain dead, nor had he executed a living will.

The nephew was concerned that he could not get the physician to remove the feeding tube which would allow his uncle to die. "You know, he said, "my uncle was a very orderly person and had all his affairs in order. You would have thought, being an attorney and all, he'd have made a living will and spared me from all of this hassle."

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The reason why the nephew called me was to ask what the policy was for the local Army medical treatment facility concerning withdrawal of the feeding tube and whether his uncle, a retired officer, could be transferred to that facility. After telling him that the Army considers feeding tubes as life-sustaining treatment, which can be removed if a patient is PVS, I went on to state my doubt that any military physician would take his uncle as a patient for the sole purpose of withdrawing the feeding tube and allowing him to die. "I figured as much, but I had to ask," he stated. After about a half an hour he thanked me for my time and concluded the conversation. I later found out from my wife that the attorney died three days later from a cardiac arrest. The feeding tube was still in place.

The situation just described, a family member's frustration and helplessness at failing to halt life-sustaining treatment that is no longer of benefit to a patient, is an increasing occurrence in many hospitals, both civilian and military. The lack of an advanced directive to abate life-sustaining treatment is something that complicates what are already heart-rending decisions made by family members during the last days of their loved one's life. A colleague once stated that the best way to become very unpopular with your immediate family is not to leave a will or a living will. Family members who must overcome the legal obstacles for making such decisions without benefit of these documents could well appreciate the wisdom of that statement.

The two principles common in bioethical literature pertaining to life-sustaining treatment and its decisions are the *autonomy* of the patient, on the one hand, and the physician's concern for doing what is best for the patient, acting *beneficiently*, on the other hand. This cooperative physician-patient partnership is, for the most part, mutually beneficial. The physician and the patient usually have the same goals—the restoration of the patient to health. There could be times, however, when the autonomous desires of the patient come into direct conflict with the beneficial inclinations of the physician. This is especially true when a patient who was previously competent is no longer able to express his or her wishes with regards to abatement of life-sustaining treatment. The physician no longer has the benefit of direct communication with the patient and must now look to a surrogate for consent for further treatment. How can the patient's autonomy be maintained by a surrogate in this situation?

That is the challenge that faces us with today's sophisticated medical technology where we are facing ever-increasing choices about our medical well-being. Just as we make decisions about how to live and remain healthy, we are now presented with opportunities to decide how to die, or at least under what medical conditions do we not want to live. The "right to die" is a topic that is receiving greater publicity as a result of recent judicial decisions.

The purpose of this article is to present an overview of the ethical and legal implications of the right to die, examine the *Cruzan* case and its impact on patient and surrogate choices about abatement of life-sustaining treatment, and to identify types of advanced directives that are available in many jurisdictions for patients to indicate their wishes about the use of life-sustaining treatment. Hopefully, reflection on these three aspects will enhance unit and

hospital ministry team understanding so that we can minister to service members and their families when they are confronted with such vital decisions.

I. The Right to Die

The phrase *right to die* is increasingly being used by the public and the legal profession to apply to an individual's right to refuse medical treatment that will save or sustain life, thereby resulting in death. The right to die is an evolving concept; it is an outgrowth of the law of informed decision making by an autonomous person limited by the constraints imposed by the criminal law.[1]

A. Patient Autonomy v. Physician Beneficence

Within the physician-patient relationship, autonomy is put into action when the patient authorizes (gives informed consent to) the physician to initiate a medical plan for his or her treatment. Personal autonomy has been defined as the personal rule of the self while remaining free from both controlling interferences by others and personal limitations that prevent meaningful choices.[2] It follows, then, that an informed consent occurs if a patient with substantial *understanding* and in substantial *absence of control* by others *intentionally authorizes* a professional to do something.[3]

Complementing this respect of autonomy is the physician's use of his or her medical expertise to help patients by diagnosing their condition, informing them about the condition, recommending the best course of action, and carrying out the agreed-upon procedure.[4] If patient autonomy and promoting the good of the patient is to be maximized, this involves identifying the benefits and burdens of treatment from the patient's perspective. If the burdens of the treatment outweigh the benefits from the patient's perspective, it is ethically acceptable to withhold or withdraw the treatment.[5]

Patient preferences for medical treatment are legally protected by our judicial system, in the legal principle of *self-determination*, because of the recognition that an adult, of sound mind, has a fundamental right to control his or her own body and the right to be protected against unwanted intrusions.[6] This right is even extended to the patient's right to prohibit the delivery of life-sustaining treatment.[7]

[1]Alan Misel, *The Right to Die* (New York: John Wiley & Sons, 1989), 14.

[2]Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 3d ed. (New York: Oxford University Press, 1989), 68.

[3]*Ibid.*, 76.

[4]Albert R. Jonsen, Mark Siegler, and William J. Winslade, *Clinical Ethics* 2nd ed., (New York: Macmillan Publishing Company, 1986), 12.

[5]The Hastings Center, *Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying* (Bloomington, IN: Indiana University Press, 1987), 19.

[6]*Schloendorff v. Society of New York Hospital.* 211 N.Y. 125, 127, 129; 105 N.E., 92, 93 (1914).

[7]*Natanson v. Kline.* 186 Kan. 393, 350 P.2d 1093, 1104 (1960). See also President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to Forego Life-Sustaining Treatment.* (Washington, D.C.: Government Printing Office, March 1983), 3.

Thus, the recognition that an adult patient has the right to accept or refuse medical care is well-established. But what happens when there is sufficient reason to believe that a patient lacks the capacity (or competency) to exercise autonomous choices for his or her medical care? How do we determine the patient's mental capacity and then take steps to safeguard the patient's autonomy if he or she lacks the capacity to decide?

Determining mental incapacity is a clinical assessment of the patient by a qualified medical professional. Tests utilized to determine mental capacity can range in difficulty from ones requiring the least ability to comprehend (a large number of persons will pass) to those in which there is a higher degree of comprehension difficulty (a small number of persons will pass). A decision about which test will be used can be as much an ethical decision as a clinical one, and will depend on the weight one wants to give to respect of autonomy against that of beneficence. If physicians are concerned about preventing abuse of autonomy, then less stringent tests would be used, whereas those physicians who accept stringent tests will place the medical interests and safety of patients above their autonomy.[8] Others advocate that the type of indicated intervention will determine the stringency of the test. If the procedure is of great benefit to the patient and has minimal risks, then a low level of mental capacity may be sufficient for authorization. However, a high level of capacity may be needed to refuse the same treatment.[9] This places the physician in a position of advantage over that of the patient. The degree of autonomy that is allowed to the patient depends upon the inclinations of individual clinicians, that is, what they think will be in the best interests of the patient.

When we anticipate a situation in which the contemplated intervention is of a life-sustaining nature, and the patient lacks decision making capacity, we are confronted with the dilemma of doing what is best for the patient without benefit of the patient's knowledge of the situation, its consequences, and his or her explicit decision about what to do. We must act in the patient's best interests without knowing what those interests are at a crucial time.

B. Substituted Judgment

Such situations have occurred in our recent past and have been the subject of many significant court cases. Both the *Quinlan*[10] and the

[8]Beauchamp, 58.

[9]Jonsen, 59.

[10]*In re Quinlan*, 137 NJ Sup 227, 348, A2d 801, modified and remanded, 70 NJ 10, 355 A2d 647, *cert denied*, 429 US 922 (1976). The New Jersey Supreme Court held that it was permissible for a guardian to disconnect Karen Ann Quinlan's respirator and allow her to die. In this case, Karen's father could draw on her life as a competent person to determine her expressed needs and wants. The court found that "if Karen herself were miraculously lucid for an interval . . . and perceptive of her irreversible condition she could effectively decide upon discontinuance of the life-support apparatus, even if it meant the prospect of a natural death."

Saikewicz[11] cases gave us the *substituted judgment standard* for proxy decision makers in medical life-sustaining treatment matters. This standard first determines the subjective wants and needs of the individual patient and then determines how a reasonable person with those wants and needs would decide.[12] This established the precedent for allowing persons other than the patient to make treatment decisions and applied it to making decisions pertaining to withdrawal and withholding life-sustaining treatments on the patient's behalf. This allowed another person to serve as an extension of the patient's autonomy.

The question that arises is what person would best be able to serve as the patient's advocate, and what criteria would they use to determine the subjective needs of the patient? Following the early court cases and the controversy surrounding them, it was felt by some that these momentous life and death treatment decisions could best be handled by the courts because of the qualities they possess that qualify them as the best decision makers: (1) the proceedings are public; (2) the judge's decision is principled (reached according to established legal principles); (3) the judicial process is impartial; and (4) it is adversarial in nature.[13] This view still tends to be exclusive and presumes that others, most notably the family and the patient's physicians cannot be principled decision makers.

On the heels of the judicial decisions of the 1970s and early 1980s, it became increasingly clear to the health care profession, the public, as well as the judicial system, that life-sustaining treatment decisions on behalf of a patient lacking decision making capacity could best be made at the bedside. Who else would be in a better position to know the patient's needs, values, and preferences than the family (acting in the patient's stead) in cooperation with the patient's physician, thus preserving the autonomy-beneficence balance that is the hallmark of the physician-patient relationship?

The federal governmental also took an interest in the subject of making life-sustaining treatment decisions. As a result, medical treatment facilities and their accrediting bodies were encouraged to formulate explicit policies to

[11]*Superintendent of Belchertown State School v. Saikewicz*, 373 Mass 728, 370 NE2d 417 (1977). The court decided that a 67 year old patient who had lived in state institutions for more than forty years (IQ was 10 and his mental age was approximately two years and eight months) did not have to receive chemotherapy for his incurable leukemia. The fundamental legal point here was that there exists "a general right in all persons to refuse medical treatment in appropriate circumstances . . . recognition of that right must extend to the case of incompetent, as well as a competent, patient because the value of human dignity extends to both."

This case differed in its application of the *substituted judgment* standard than that of *Quinlan*. Here, the lack of evidence about the incompetent's likely choice forced the court to look at what is known about other people in his particular circumstances to help determine what a reasonable person in his circumstances, with needs and desires insofar as they are ascertainable, would decide. Some writers have held that this is more an application of the *best interests* standard of proxy decision making which protects never-competent individuals from potentially serious consequences [see Beauchamp and Childress, 170-173.]

[12]Beauchamp, 172.

[13]A. Edward Doudera and J. Douglas Peters, eds., *Legal and Ethical Aspects of Treating Critically and Terminally Ill Patients* (Ann Arbor, MI: Health Administration Press, 1982), 8.

govern life-sustaining treatment and the naming of an appropriate surrogate, ordinarily a family member. The surrogate's decisions should attempt to replicate the ones the patient would make if capable of doing so.[14]

Procedurally, then, an incapacitated patient's autonomy would seem to be protected. However, there is a danger of infringement by the physician of what a patient would want concerning life-sustaining treatment. Most natural death acts and hospital life-sustaining treatment polices contain the proviso that a previously-competent patient's directive (or "living will") shall be complied with unless the physician believes that the directive does not reflect the *present desire* of the patient, or that there is a reason to believe that the patient *may have* changed his or her mind.[15] While this apparent "loophole" may have been inserted so as not to tie the hands of the beneficent attending physician or the concerned family members in making on-the-spot decisions about the immediate situation, I have observed a number of situations it has been utilized to completely disregard the explicitly-stated autonomous wishes of a previously-competent patient. The reason given for this apparent disregard of the patient's wishes is that the patient could not have foreseen the current situation, therefore, his or her wishes are inoperable or irrelevant.

There apparently is no ironclad way to guarantee that a patient's autonomy is given full-expression in these situations. However, the best attempt at closing this "loophole" inherent in advanced treatment directives is the naming of an agent in a durable power of attorney who can make proxy decisions to carry out an incapacitated patient's wishes. This point will be discussed more fully later.

II. The *Cruzan* Case

A. The Plight of Nancy Cruzan

In January 1983, Nancy Cruzan, a 25-year old woman, sustained serious injuries from an automobile accident which left her in a persistent vegetative state. Her brain had atrophied, she was totally unaware, and there was no hope that she would ever recover cognitive brain function. Artificial hydration and nutrition sustained her life.

Nancy's parents had asked that all artificial life supports, including the feeding tube be withdrawn. They were convinced from statements that Nancy had made to close friends that she would not want to live should she face life as a "vegetable."[16] Officials at the Missouri State Rehabilitation Hospital refused to disconnect the tube. The Cruzans appealed to the courts and, on July 27, 1988, the circuit judge ruled that the feeding tube could be disconnected on the grounds that continuing life-sustaining treatment would be a

[14]President's Commission, 5-9.

[15]Wording is paraphrased from Texas Natural Death Act. Texas Health and Safety Code, chapter 672 (Vernon Supp. 1991, section 8(c), and Department of the Army, *Army Regulation 40-3: Medical, Dental, and Veterinary Care*, chap. 19, "Do-Not-Resuscitate or 'No-Code' Orders," para. 19-2a.

[16]Robert F. Weir and Larry Gostin, "Decisions About Abatement of Life-Sustaining Treatment for Nonautonomous Patients," *JAMA* 264, no. 14 (October 10, 1990): 1846.

violation of Nancy Cruzan's constitutional right to liberty. Denying her parents permission, as coguardians, to act in her behalf would deprive her of equal protection of the law. The judge directed the hospital authorities to disconnect the feeding tubes. Immediately, however, a court appointed guardian *at litem*, who acted as Nancy Cruzan's advocate at court hearings, appealed the circuit court judge's decision to the Missouri Supreme Court.[17]

Four months later, on November 16, 1988, the Missouri Supreme Court reversed the lower court's ruling. The 5-4 majority opinion stated that the feeding tube was "not heroically invasive" or a "painful invasion" or "oppressively burdensome," nor was it medical treatment. The court ruled that the "state's interest in the preservation of life," of particular importance when the ward is not terminally ill, is "unqualified," and under the circumstances outweighed Nancy's constitutional right of privacy or her common law right of refusal.[18]

Furthermore, the majority opinion questioned the legitimacy of Nancy's parent's substituted judgment to terminate treatment for an incompetent person in the absence of clear and convincing evidence of her wishes.[19] The right to privacy and the common law right to refuse treatment cannot be exercised by third parties. "A guardian's power to exercise third party choices arises from the state's authority, not the constitutional right of the ward. The guardian is the delegatee of the state's *parens patriae* power."[20] Hence, it would seem that guardians, as Nancy's parents were, must promote the state's unqualified interest in the preservation of life. Finally, the court ruled that evidence of Nancy's wishes was "unreliable for the purposes of determining her intent," was "insufficient to support" the coguardians' exercise of substituted judgment, and was outweighed by the state's interest in the preservation of life.[21]

The main issues brought out in the *Cruzan v. Harmon* case that deserve our attention are: (1) artificial feeding (hydration and nutrition) are not considered medical treatment, (2) persistent vegetative state is not defined as terminal illness, (3) the state's interest in preserving life required clear and convincing evidence that the person (in this case, Nancy Cruzan) would want otherwise, and (4) guardians function to act in the state's, and not the patient's, behalf. Normally, right to die cases are the domain of lower courts and not that of the United States Supreme Court. In this instance, however, the Cruzan's attorneys saw the opportunity to present the case to the highest court as a violation of Nancy's Fourteenth Amendment right to liberty and privacy to refuse life-sustaining treatment. When the Supreme Court decided to review the case, the health care and bioethics community and right to die supporters recognized the potential impact on abatement of life-sustaining treatment throughout the country should the Missouri Supreme Court's decision be upheld.

[17]Ron Hammel, "A Time to Die: The Cases of Nancy Cruzan and Janet Adkins," *Bulletin of the Park Ridge Center*, 5, no. 3 (September 1990): 17-18.

[18]*Ibid.*, 18.

[19]Weir, 1847.

[20]*Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988.)

[21]Hammel, *Ibid.*

At the time the *Cruzan* case went before the Supreme Court, 40 states and the District of Columbia had statutes concerned with living wills. A durable power of attorney specifically for health care decisions was recognized in 25 states and the District of Columbia.[22] Would a Supreme Court ruling require that all states adopt the "clear and convincing evidence" criteria? Would artificial hydration and nutrition be excluded from life-sustaining treatment, thus making it mandatory for all patients who are not "qualified" as terminally ill? Would guardians now be required to place state interests over that of the best interest of the patient, thus restricting "substituted judgment?"

B. Cruzan v. Director, Missouri Department of Health

On June 26, 1990, the United States Supreme Court handed down its decision, which essentially upheld the Missouri Supreme Court's decision. Chief Justice William H. Rehnquist wrote the 5-4 majority opinion.

While acknowledging that a competent person has a constitutional right to refuse life-sustaining medical treatment on the basis of "liberty interests" (not privacy) protected by the Fourteenth Amendment, the Court held that there is nothing in the United States Constitution that forbids Missouri from establishing the procedural "clear and convincing evidence" requirements it did for decision making by surrogates for incompetent patients.[23] The decision explained that "an incompetent person is not able to make an informed and voluntary choice to exercise a hypothetical right. Such a 'right' must be exercised for her, if at all, by some sort of surrogate." Missouri established procedural safeguards to assure that the decision of the surrogate "conform as best it may to the wishes expressed by the patient while competent." Missouri's interest in the protection and preservation of human life, especially those who are no longer competent to do so, required the "clear and convincing evidence" safeguard. While the Supreme Court had no reason to doubt the Cruzans' sincerity, the justices stated that there was no assurance that the Cruzans' views regarding termination of treatment necessarily corresponded to what Nancy would choose if she were competent. For this reason the Court concluded that the state may choose to defer only to the patient's wishes rather than that of the family.[24]

In a concurring opinion, Justice Sandra Day O'Conner included artificially administered nutrition and hydration in the category of "medical treatment." She also made the point that the Court's decision "does not preclude a future determination that the Constitution requires the states to implement the decisions of a patient's duly appointed surrogate." O'Conner stated that such a duty may be constitutionally required to protect the patient's liberty

[22]Pat Milmoe McCarrick, "Living Wills and Durable Powers of Attorney: Advanced Directive Legislation and Issues," *National Reference Center for Bioethics Literature, SCOPE NOTE 2* rev. (Washington, D.C.: Kennedy Institute of Ethics, March 1990), 2, 4.

[23]Ron Hammel, "The Supreme Court's Decision in the *Cruzan* Case: A Synopsis," *Bulletin of the Park Ridge Center* 5, no. 3 (September 1990): 18.

[24]*Ibid.*

interests in refusing medical treatment. Developing procedures for safeguarding an incompetent's liberty interests is left to the "laboratory of the states."[25]

The *Cruzan* decision essentially gave competent adults a constitutionally-protected right to refuse life-sustaining treatment. However, when a surrogate must make the decision, each state is allowed to establish procedures that may remove decision making powers from surrogates if they do not meet the evidentiary standards required by the state in such cases. Those standards may include "clear and convincing" evidence that the incompetent patient would have decided to remove life-sustaining treatment (Missouri and New York are the only states that have adopted this standard for removal of feeding tubes).[26] Most states, however, require only that a surrogate have knowledge of the patient's preferences either from previous conversations with the patient about abatement of life-sustaining treatment or from having shared values with the patient that would allow them to make a reasoned determination of what would be in the best interests of the patient.*

Cruzan will not constitutionally protect the never-autonomous patient (i.e., mentally retarded, or young children who never expressed preferences), the once-autonomous patient who failed to express preferences about their future treatment, or the once-autonomous patient who expressed views insufficiently exact to meet the "clear and convincing" standard. This case, however, will have the positive effect in that it will encourage persons to formulate advanced directives, sign durable power of attorney forms, and express their views regarding life-sustaining treatment to family members and physicians before the onset of critical illness.[27]

C. Patient Self-Determination Act

One direct result of the *Cruzan* decision is the enactment of the Patient Self-Determination Act sponsored by Senators John Danforth (R-MO) and Daniel Moynihan (D-NY), and Representative Sander Levin (D-MI), and passed as part of the Omnibus Budget Reconciliation Act of 1990. This act, which takes effect in December 1991, affects all health care facilities, including hospitals, nursing homes and hospices receiving Medicare or Medicaid. It stipulates that "individuals must be given written information at the time of admission about their rights under state law to accept or refuse medical treatment and the right to formulate advanced directives such as Living Wills and durable powers of attorney for health care." The facilities will be responsible for documenting "in each individual's medical record" whether he or she has executed an advanced directive. In addition, the facilities are required to undertake public education programs for staff and the community

*On 2 November 1990 the Cruzan case was reopened in the same Missouri court when three friends of Nancy Cruzan offered further clear and convincing evidence she would not wish to remain in a permanent vegetative state. Nancy's guardian *at litem* expressed no objections. The feeding tube was removed and Nancy died on 26 December 1990.

[25]*Ibid.*, 20.
[26]Weir, 1847.
[27]*Ibid.*

on issues concerning advanced directives. States are required to develop a written description of the state law on advanced directives.[28]

The U.S. Department of Health and Human Services Secretary is required, within six months of the enactment of this law, to develop and implement a massive public education campaign on the option to execute advanced directives and to provide written materials to health care facilities for distribution to patients at the time of their admission to hospitals. Information will also be provided at the time of an individual's admission as a resident to a skilled nursing facility, in advance of an individual coming under the care of a home health agency, at the time of the initial receipt of an individual by a hospice program, or at the time of enrollment of an individual in an eligible managed care program.[29]

The most controversial provision of this act, and the one that received the greatest opposition, is that "The secretary [of Health and Human Services] will not provide for [Medicare or Medicaid] payment . . . unless the organization provides assurances satisfactory to the secretary that the organization meets the requirements . . . relating to maintaining written policies and procedures respecting advanced directives."[30] Senator Danforth pushed for the stiff new requirements, noting that fewer than 10% of competent adults in the U.S. have signed a living will, and that even fewer have executed a durable power of attorney.[31]

III. Advanced Directives

The Patient Self-Determination Act is an innovative law. It will undoubtedly ensure that more Americans will learn about their rights to accept or refuse medical treatment, especially treatment associated with the sustainment of life. However, mere knowledge of their rights is no guarantee that individuals will exercise those rights. A survey done by the American Medical Association found that only 56% of patients had discussed such health care decision making with the family and that only 15% had executed living wills.[32] However, the Society for the Right to Die has indicated a tremendous upsurge in the number of inquiries about advanced directives.

In order to protect their autonomy in the event of critical or terminal illness, many people execute written advanced directives, usually known as living wills. The laws governing these documents are known as "natural death" or "death with dignity" statutes, and offer a patient, the family, and health care providers legal protection and directions for future treatment aimed at keeping health decisions free from court action.[33]

[28]Concern for Dying and Society for the Right to Die, Press release announcing the passage of the Patient Self-Determination Act, undated.

[29]American Health Consultants, *Medical Ethics Advisor*, ed. C.B. Hackworth, 7, no. 1 (January 1991): 3.

[30]*Ibid.*

[31]John C. Danforth, Opening statement before the Senate Subcommittee on medicare and Long Term Care of the Committee on Finance hearing on the Patient Self-Determination Act, Washington, D.C., July 20, 1990.

[32]*Medical World News* 30, no. 4 (July 20, 1989): 26-27.

[33]McCarrick, 2.

Some persons oppose living wills on the basis that the documents may appear to erode established patient rights. Other persons disagree with the concept of living wills because their existence may leave the door open for an acceptance of active mercy killing, or *euthanasia*, by patients, health care providers, or by society in general.[34]

Some physicians indicate that those charged with direct patient care will be hampered in providing treatment that is of benefit to the patient in certain situations that could not possibly have been foreseen by the writer of the living will. According to one physician:

> There are few absolutes at the bedside. For this reason, living will legislation in some states provides for directives to physicians that are merely advisory about the patient's preference. Physicians may sometimes act against these preferences if conditions arise that may not have been foreseen by the patient. For example, patients may refuse the respirator (anticipating dying by heart failure or cancer.) They come to the hospital for a biopsy and acquire the iatrogenic disease of septic shock. The physician has, in a real way, caused this disease, and since it is under certain circumstances reversible, to benefit the patient a decision requires treatment until the patient can fully comprehend the actual circumstances and reassess his or her wishes in light of the circumstances.[35]

A. Living Will Laws

On January 1, 1977, California's Natural Death Act became the first law to give legal force to living wills. Currently 41 states and the District of Columbia have statutes concerned with living wills. At present, nine states do not have legislation pertaining to advanced directives for the terminally ill: Massachusetts, Michigan, New Jersey, New York, Nebraska, Ohio, Pennsylvania, Rhode Island, and South Dakota. At the time of this writing, South Dakota was in the process of passing a living will statute; only Pennsylvania lacks pending legislation.[36]

In the jurisdictions that do have statutes, there are variations in instructions for those who wish to execute a living will. Many states have stipulated or suggested wording which is found in the statute. The Society for the Right to Die and Concern for the Dying have specific texts available for those states requiring such documents, and also generic advanced directive forms for others.

[34]*Ibid.*

[35]Edmund Pellegrino and David Thomasma, *For the Patient's Good: The Restoration of Beneficence in Health Care* (New York: Oxford University Press, 1988), 19.

The view that directive to physicians are merely advisory about the patient's preference and are not binding on physicians is also apparently shared by the Army Medical Department. In a recent memorandum pertaining to the placement of living wills in patient treatment records that was sent by the Office of the Surgeon General, U.S. Army, to major Army medical commands throughout the world, the following words appear: "When the patient executes a living will, it is his/her intent to communicate his/her wishes to health care providers; living wills are not legal, binding documents." [Department of the Army, Office of the Surgeon General, ATTN: SGPS-PSA, Washington, D.C., Memorandum, dtd 9 November 1990, Subject: Placement of Living Wills in Outpatient Treatment Records, Health Records, and Inpatient Treatment Records.]

[36]The Society for the Right to Die and Concern for the Dying, 250 West 57th St., New York, N.Y. 10107, (212) 246-6973 or (800) 248-2122.

To understand some of the requirements for a living will, let's examine one state's living will form. Texas' "Directive to Physicians" *(Figure 1)* is taken from suggested wording found in the current Texas Natural Death Act.[37] The statute does not require you to follow precisely the form it contains, but it permits you to add specific instructions of your own, to include the designation of a *proxy* to make decisions on your behalf when you are in a terminal condition, as defined in the Act.[38] This designation of a proxy is distinct from the agent designated in the state's durable power of attorney for health care. In this case, the proxy would make treatment decisions if you are in an "incurable or irreversible condition" *and* do not possess the "ability to give directions regarding the use of life-sustaining procedures."

There are some restrictions as to who may witness and sign the Directive. Individuals who are related by blood or marriage, who stand to inherit or have a claim against your estate, and health care providers are prohibited from serving as witnesses. After executing the Directive it is important for you to discuss its provisions with your doctor and family members and to keep a copy of the Directive with your important papers. According to the Texas law, the disclosure of the existence of the Directive to the attending physician is required for the provisions contained therein to be carried out.

Potential legal problems that also had clinical implications were cleared up by the most recent amendment to the Texas Natural Death Act: the definition of *terminal condition* and *imminence of death.* Also, the Act does not appear to mention anything about abatement of *artificial hydration and nutrition.* I raise these issues because of their controversial aspects that may not be resolved in other states' natural death acts.

The 1989 Texas Natural Death Act amendments revised the definition of terminal condition to include *incurable* and *irreversible conditions* caused by injury, disease, or illness, a clarification that allows for consideration of irreversible coma, persistent vegetative state, and even possible irreversible dementia. Also, the requirement that death occur regardless of the use of life-sustaining procedures was changed to clarify that a condition is considered terminal where, within reasonable medical judgment, death would occur "*without* the application of life-sustaining procedures."[39]

The 1989 Texas legislature clarified the "imminence" of death requirement. It changed the definition of life-sustaining procedures to include not only artificial medical interventions that prolong the moment of death where death is imminent, but also in situations where death "will result within a relatively short time without the application of such procedures."[40] Thus, no

[37]Natural Death Act, Tex. Stat. Ann. art 4590h (1977, amended 1979, 1983, 1985, 1989), now Texas Health and Safety Code, chap. 672, sec. 3(d)(amended).

[38]Society for the Right to Die, "How to Use the DIRECTIVE TO PHYSICIANS Authorized by the TEXAS NATURAL DEATH ACT," undated. Space has been provided on this form supplied by the Society for the Right to Die for you to include your proxy's name and other personal instructions such as, "I do not want antibiotics, surgery, cardiac resuscitation, a respirator, artificial feeding . . . " You might want to emphasize your desire to be kept comfortable and pain free even though medication may shorten your life.

[39]Dolores M. Garlo, "The Texas Natural Death Act: Interpretation, Application and Fine-Tuning," *Texas Bar Journal* (January 1990): 14.

[40]*Ibid.*, 15.

TEXAS

DIRECTIVE TO PHYSICIANS

Directive made this _____ day of _____ (month, year).

I _____, being of sound mind, willfully and voluntarily make known my desire that my life shall not be artificially prolonged under the circumstances set forth below, and do hereby declare:

1. If at any time I should have an incurable or irreversible condition caused by injury, disease, or illness certified to be a terminal condition by two physicians, and where the application of life-sustaining procedures would serve only to artificially prolong the moment of my death and where my attending physician determines that my death is imminent or will result within a relatively short time without application of life-sustaining procedures, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally.

2. In the absence of my ability to give directions regarding the use of life-sustaining procedures, it is my intention that this directive shall be honored by my family and physicians as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

Other directions:

3. If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive shall have no force or effect during the course of my pregnancy.

4. This directive shall be in effect until it is revoked.

5. I understand the full import of this directive and I am emotionally and mentally competent to make this directive.

6. I understand that I may revoke this directive at any time.

Signed _____

City, County, and State of Residence _____

I am not related to the declarant by blood or marriage; nor would I be entitled to any portion of the declarant's estate on his/her decease; nor am I the attending physician of the declarant or an employee of the attending physician; nor am I a patient in the health care facility in which the declarant is a patient, or any person who has a claim against any portion of the estate of the declarant upon his/her decease. Furthermore, if I am an employee of a health facility in which the declarant is a patient, I am not involved in providing direct patient care to the declarant nor am I directly involved in the financial affairs of the health facility.

Witness _____

Witness _____

This Directive complies with the Natural Death Act, Tex. Stat. Ann. art 4590h (1977, amended 1979, 1983, 1985, 1989).

Courtesy of the Society for the Right to Die, 250 W. 57th Street, New York, NY 10107

definite time limit was set for what constitutes imminent death. Such determination is to be made by the attending physician in consultation with a concurring physician.

With regards to whether the use of artificial hydration and nutrition is considered a life-sustaining procedure under Texas law, one must look at clear trends in the law. Many courts have rejected any distinction between the termination of artificial feeding and life-sustaining procedures. As a result, procedures for artificial feeding, which bypass the natural process of eating and drinking have been treated as life-sustaining procedures.[41] In interpreting the Texas Natural Death Act, the attorney general of Texas has indicated that artificial or tube feeding may meet the definition of a life-maintaining procedure, but that when to forego such feeding is a fact question that depends on the expertise of the medical profession for resolution.[42]

B. Limitations of Living Wills

While living wills are a means of indicating an individual's wishes pertaining to life-sustaining treatment, as we have already mentioned, they do have some limitations. Because of their nature, living wills focus on the individual's desire to have medical treatment terminated. To many people, including physicians, living wills seem to be for the rejection of care rather than an opportunity for the patient to outline in advance a full range of preferences about medical care, including desires to have specific types of treatments administered.[43]

Standard living will formats use vague terminology which hinders clear understanding of what is meant when a patient is in a certain stated medical condition and can create interpretation problems regarding the types of interventions that are to be terminated. We've already seen several examples of this uncertainty in the Texas Directive to Physicians. Also, by not taking into account the wide range of clinical possibilities, living wills appear to be too inflexible for individualized patient care. The fact that provisions of the living will are not discussed with family members and attending physicians can lead to many misconceptions and misinterpretations that can cause more problems than the living will was meant to solve.

These problems just mentioned can be substantially relieved with a more specific and inclusive advanced medical directive. One such document has been designed by Doctors Linda and Ezekiel Emanuel

[41]*Gray v. Romero*, 697 F. Supp. 580 (D.R.I. 1988) [there is no legal difference between a mechanical device for artificial breathing and a mechanical device for artificial nourishment.]; *In re Grant*, 747 P.2d 445 (Wash. 1987) [nasogastric tubes and intravenous infusions are different than human ways of providing nutrition because an artificial devise is used to prolong life due to loss of vital bodily function]; *Barber v. Superior Court*, 147 Cal. App. 3d 1006 Cal Rptr. 484 (1983) [refusing to draw a distinction between mechanical breathing devices and mechanical feeding devices such as intravenous tubes]. See also O'Conner concurring decision in *Cruzan v. Director, Missouri Department of Health* mentioned earlier in this article.

[42]Garlo, 16., referring to Op. Tex. Att'y Gen. No. JM-837 (December 28, 1987).

[43]Marshall B. Kapp, "Response to the Living Will Furor: Directives for Maximum Care," *American Journal of Medicine* 72 (1982): 855-859.

(Figures 2a-c on next pages).[44] This Medical Directive is divided into five parts: (1) an introduction, (2) a section containing four paradigmatic scenarios of illness in which preferences for medical care are given, (3) a section for the designation of a proxy decision maker, (4) a section for organ donations, and (5) a personal statement.

The introduction provides an explanation of an advanced care document, gives instructions on how to complete the form, and then suggests what to do with the form once it is completed, signed, and witnessed. Of crucial importance here is to give a copy to your personal physician, family members and/or friend and discuss its provisions with them.

The central part of the Directive is the section containing the four scenarios with twelve medical treatments/procedures to select for each scenario. The four illness scenarios are defined by disability and prognosis and are paradigmatic in two ways: (1) they encompass the spectrum of types of mental incompetence, and (2) they represent the principal circumstances arising in medical practice that have prompted legal cases. In each of these scenarios you are asked to indicate whether you would want or not want interventions in the 12 treatment categories. You may also indicate if you want the treatment tried on a trial basis and discontinued if there is no clear improvement.[45]

In the section pertaining to the durable power of attorney, the designated proxy would be called on in circumstances not covered by one of the scenarios or in cases where the patient has expressed uncertainty. There is also a designation as to which will take precedence if there is a difference, the proxy or the written instructions in the Medical Directive. Instructions are also made pertaining to organ donation, and a personal statement can be made to provide additional instructions for any of the preceding scenarios or guidelines.

The authors' intent for this Medical Directive is to greatly reduce the medical and linguistic vagueness of current living wills, to provide more specificity in positive treatment options that provide stronger evidence of a patient's wishes, and to induce an open and frank discussion between the patient and his or her physician and family members in a proactive rather than a reactive manner. It is much better to deliberate on these matters in advance

[44]Printed under a limited license granted, through the writer of this article, to the *Military Chaplains' Review* which has no rights to grant additional reprint requests or other permissions for the reproduction of the Medical Directive.

a. Copyright 1990 by Linda L. Emanuel and Ezekiel J. Emanuel. The authors of this form advise that it should be completed pursuant to a discussion between the principal and his or her physician, so that the principal can be adequately informed of any pertinent medical information, and so that the physician can be appraised of the intentions of the principal and the existence of such a document which may be made part of the principal's medical records.

b. This form was originally published as part of an article by Linda L. Emanuel and Ezekiel J. Emanuel, "The Medical Directive: A New Comprehensive Advanced Care Document" in *Journal of the American Medical Association*, 261, no. 22 (June 9, 1989): 3290. It does not reflect the official policy of the American Medical Association.

c. Copies of this form may be obtained from the Harvard Medical School Health Letter, 164 Longwood Avenue, Boston, MA 02115 at 2 copies for $5 or 5 copies for $10; bulk orders are also available.

[45]Emanuel, *JAMA*, 3291.

The Medical Directive

Introduction. As part of a person's right to self-determination, every adult may accept or refuse any recommended medical treatment. This is relatively easy when people are well and can speak. Unfortunately, during severe illness people are often unconscious or otherwise unable to communicate their wishes—at the very time when many critical decisions need to be made.

The Medical Directive states your wishes regarding various types of medical treatment in several representative situations so that your desires can be respected. It comes into effect only if you become incompetent (unable to make decisions or to express your wishes), and you can change it at any time until then. As long as you are competent, you should discuss your care directly with your physician.

The Medical Directive also lets you appoint someone to make medical decisions for you if you should become unable to make your own; this is a proxy or durable power of attorney. Additionally, it contains a statement of your wishes concerning organ donation.

The following three pages contain a Medical Directive form on which you can record your own desires. Since such wishes usually reflect personal, philosophical, and religious views, you may want to discuss the issues with your family, friends, or religious mentor before completing the form.

Completing the Form. First you will be asked to consider four different situations that involve mental incompetence: an irreversible coma or a persistent vegetative state (situation A); a coma with very slight and uncertain chance of recovery (situation B); irreversible brain damage or brain disease together with a terminal illness (situation C); and irreversible brain damage or disease but with no terminal illness (situation D). For each of these situations, you will be asked to indicate your wishes concerning possible medical interventions ranging from pain medications to resuscitation. You can refuse a certain treatment or request that it definitely be used, should it be medically appropriate. Alternatively, you can state that you are unsure about your preference for the treatment, or that you would like it tried for a while but discontinued if it does not result in definite improvement. This phase of completing the Medical Directive is best done in discussion with your physician.

Next you will be given the opportunity to designate a proxy decision-maker. This person would be asked to make decisions under circumstances in which your wishes are unclear—for example, if your situation is not covered in this document or if your preference is undecided. (It is expected, in the former case, that the proxy would be significantly guided whenever possible by your choices in situations A–D.) You can indicate whether the proxy's decisions should override (or be overridden by) your wishes. And, should you name more than one proxy, you can state who is to have the final say if there is disagreement.

Then you will be able to express your preference concerning organ donation. Do you wish to donate your body or some or all of your organs after your death? If so, for what purpose(s) and to which physician or institution?

Before recording a personal statement in the Medical Directive, you may find it helpful to consider the following question. What kind of medical condition, if any, would make life hard enough that you would find attempts to prolong it undesirable? None? Intractable pain? Permanent dependence on others? Irreversible mental damage? Another condition you would regard as intolerable? Under circumstances such as these, medical intervention may include only securing comfort; it may involve using ordinary treatments while avoiding more invasive ones; or employing those that offer improved function; or trying anything appropriate to prolonging life—regardless of quality. You should record here anything you feel is necessary to clarify your personal values concerning the limits of life and the goals of medical intervention.

What to Do with the Form. Finally, to make the Medical Directive effective you will need to sign and date it in the presence of two witnesses. They must sign and date the form as well. You don't need to have it notarized. States vary in the details of legislation covering documents of this sort. If you wish to know the laws in your state, you should call the office of its attorney general or consult a lawyer privately. If your state has a statutory document, you may want to complete the Medical Directive and append it to this form.

You should give a copy of the completed document to your personal physician, as well as to a family member or a friend, to ensure that it will be available if it is needed. Your physician should have a copy of it placed in your medical records and should flag it so that anyone who might be involved in your care can be aware of its presence.

Adapted with permission from L. L. Emanuel and E. J. Emanuel, "The Medical Directive: A New Comprehensive Advance Care Document," *JAMA* 261:3288-3293, June 9, 1989. Published as a supplement to the *Harvard Medical School Health Letter*, June 1990.

MY MEDICAL DIRECTIVE

This Medical Directive expresses, and shall stand for, my wishes regarding medical treatments in the event that illness should make me unable to communicate them directly. I make this Directive, being 18 years or more of age, of sound mind, and appreciating the consequences of my decisions.

SITUATION A

If I am in a coma or a persistent vegetative state and, in the opinion of my physician and several consultants, have no known hope of regaining awareness and higher mental functions no matter what is done, then my wishes regarding use of the following, if considered medically reasonable, would be:

SITUATION B

If I am in a coma and, in the opinion of my physician and several consultants, have a small likelihood of recovering fully, a slightly larger likelihood of surviving with permanent brain damage, and a much larger likelihood of dying, then my wishes regarding use of the following, if considered medically reasonable, would be:

SITUATION C

If I have brain damage or some brain disease that in the opinion of my physician and several consultants cannot be reversed and that makes me unable to recognize people or to speak understandably, *and I also have a terminal illness*, such as incurable cancer, that will likely be the cause of my death, then my wishes regarding use of the following, if considered medically reasonable, would be:

SITUATION D

If I have brain damage or some brain disease that in the opinion of my physician and several consultants cannot be reversed and that makes me unable to recognize people or to speak understandably, *but I have no terminal illness*, and I can live in this condition for a long time, then my wishes regarding use of the following, if considered medically reasonable, would be:

	I want	I want treatment tried. If no clear improvement, stop.	I am undecided	I do not want
Cardiopulmonary Resuscitation: if at the point of death, using drugs and electric shock to keep the heart beating; artificial breathing.		Not applicable		
Mechanical Breathing: breathing by machine.				
Artificial Nutrition and Hydration: giving nutrition and fluid through a tube in the veins, nose, or stomach.				
Major Surgery, such as removing the gall bladder or part of the intestines.		Not applicable		
Kidney Dialysis: cleaning the blood by machine or by fluid passed through the belly.				
Chemotherapy: using drugs to fight cancer.				
Minor Surgery, such as removing some tissue from an infected toe.		Not applicable		
Invasive Diagnostic Tests, such as using a flexible tube to look into the stomach.		Not applicable		
Blood or Blood Products, such as giving transfusions.				
Antibiotics: using drugs to fight infection.				
Simple Diagnostic Tests, such as performing blood tests or x-rays.		Not applicable		
Pain Medications, even if they dull consciousness and indirectly shorten my life.		Not applicable		

	I want	I want treatment tried. If no clear improvement, stop.	I am undecided	I do not want
Cardiopulmonary Resuscitation: if at the point of death, using drugs and electric shock to keep the heart beating; artificial breathing.		Not applicable		
Mechanical Breathing: breathing by machine.				
Artificial Nutrition and Hydration: giving nutrition and fluid through a tube in the veins, nose, or stomach.				
Major Surgery, such as removing the gall bladder or part of the intestines.		Not applicable		
Kidney Dialysis: cleaning the blood by machine or by fluid passed through the belly.				
Chemotherapy: using drugs to fight cancer.				
Minor Surgery, such as removing some tissue from an infected toe.		Not applicable		
Invasive Diagnostic Tests, such as using a flexible tube to look into the stomach.		Not applicable		
Blood or Blood Products, such as giving transfusions.				
Antibiotics: using drugs to fight infection.				
Simple Diagnostic Tests, such as performing blood tests or x-rays.		Not applicable		
Pain Medications, even if they dull consciousness and indirectly shorten my life.		Not applicable		

	I want	I want treatment tried. If no clear improvement, stop.	I am undecided	I do not want
Cardiopulmonary Resuscitation: if at the point of death, using drugs and electric shock to keep the heart beating; artificial breathing.		Not applicable		
Mechanical Breathing: breathing by machine.				
Artificial Nutrition and Hydration: giving nutrition and fluid through a tube in the veins, nose, or stomach.				
Major Surgery, such as removing the gall bladder or part of the intestines.		Not applicable		
Kidney Dialysis: cleaning the blood by machine or by fluid passed through the belly.				
Chemotherapy: using drugs to fight cancer.				
Minor Surgery, such as removing some tissue from an infected toe.		Not applicable		
Invasive Diagnostic Tests, such as using a flexible tube to look into the stomach.		Not applicable		
Blood or Blood Products, such as giving transfusions.				
Antibiotics: using drugs to fight infection.				
Simple Diagnostic Tests, such as performing blood tests or x-rays.		Not applicable		
Pain Medications, even if they dull consciousness and indirectly shorten my life.				

	I want	I want treatment tried. If no clear improvement, stop.	I am undecided	I do not want
Cardiopulmonary Resuscitation: if at the point of death, using drugs and electric shock to keep the heart beating; artificial breathing.		Not applicable		
Mechanical Breathing: breathing by machine.				
Artificial Nutrition and Hydration: giving nutrition and fluid through a tube in the veins, nose, or stomach.				
Major Surgery, such as removing the gall bladder or part of the intestines.		Not applicable		
Kidney Dialysis: cleaning the blood by machine or by fluid passed through the belly.				
Chemotherapy: using drugs to fight cancer.				
Minor Surgery, such as removing some tissue from an infected toe.		Not applicable		
Invasive Diagnostic Tests, such as using a flexible tube to look into the stomach.		Not applicable		
Blood or Blood Products, such as giving transfusions.				
Antibiotics: using drugs to fight infection.				
Simple Diagnostic Tests, such as performing blood tests or x-rays.		Not applicable		
Pain Medications, even if they dull consciousness and indirectly shorten my life.				

DURABLE POWER OF ATTORNEY

I understand that my wishes expressed in these four cases may not cover all possible aspects of my care if I become incompetent. I also may be undecided about whether I want a particular treatment or not. Consequently, there may be a need for someone to accept or refuse medical interventions for me in consultation with my physicians. I authorize

_____

_____

as my proxy(s) to make the decision for me whenever my wishes expressed in this document are insufficient or undecided.

Should there be any disagreement between the wishes I have indicated in this document and the decision favored by my above-named proxy(s),

(Please delete one of the following two lines.)

I wish my proxy(s) to have authority over my Medical Directive.

(or)

I wish my Medical Directive to have authority over my proxy(s).

Should there be any disagreement between the wishes of my proxies,

_____ shall have final authority.

ORGAN DONATION

I hereby make this anatomical gift to take effect upon my death.

(Please check boxes and fill in blanks where appropriate.)

I give

☐ my body;

☐ any needed organs or parts;

☐ the following organs or parts _____

_____

to

☐ the following person or institution: _____

_____

☐ the physician in attendance at my death;

☐ the hospital in which I die;

☐ the following named physician, hospital, storage bank, or other medical institution: _____

_____

for the following purposes:

☐ any purpose authorized by law;

☐ therapy of another person;

☐ medical education.

☐ transplantation;

☐ research;

MY PERSONAL STATEMENT (use another page if necessary)

_____

_____

_____

Signed _____ Date _____

Witness _____ Date _____

Witness _____ Date _____

of their occurrence rather than at a time when stress is greater and emotions are more intense.

C. Durable Power of Attorney

Another method of planning for health care decisions in the event that a person lacks decision making capacity is to name an agent in a durable power of attorney who can make decisions to carry out the patient's wishes. The general power of attorney is legal in 50 states and the District of Columbia, however, only 37 states and the District of Columbia have recognized a durable power of attorney specifically for making health care decisions. (*Map indicates state status of durable powers of attorney.* NOTE: Since the publishing of the map, Wyoming has passed a durable power of attorney statute that permits agents to make medical decisions, specifically including decisions to withdraw or withhold life support.)[46]

Using the example of Texas' Durable Power of Attorney for Health Care (*Figures 3a-c on next pages*),[47] we can examine some of the features of such directives. (It's important to familiarize yourself with the specific provisions of the durable power of attorney law of your state before executing one.)

Texas law permits you to appoint an agent specifically authorized to make medical treatment decisions on your behalf. These can include the decision to refuse or withdraw consent to medical treatment. The agent can make medical decisions for you when you lack the capacity to make them for yourself, *regardless of whether or not you are in a terminal condition.*[48]

The agent may be anyone except your health or residential care provider or an employee of the residential health care provider, unless they are related to you.[49] The same restrictions apply for signing and witnessing of the durable power of attorney as previously stated for the Directive for Physicians. These witnesses must affirm that you appear to be of sound mind to make a health care decision at the time of signing the document. Difficulty arises if you are hospitalized or ill at home. Then, your attending physician will have to make a statement that, in his or her best medical judgment, you are of sound mind to make a health care decision. Texas law also allows the principal who is physically unable to sign the power of attorney to have another person sign the principal's name in the principal's presence at the express direction of the principal.[50]

There is a lengthy disclosure form that explains the purpose, provisions, and restrictions of the durable power of attorney that you must sign before execution of the document. A similar form is required by California

[46]Permission to reproduce map granted by the Society for the Right to Die.

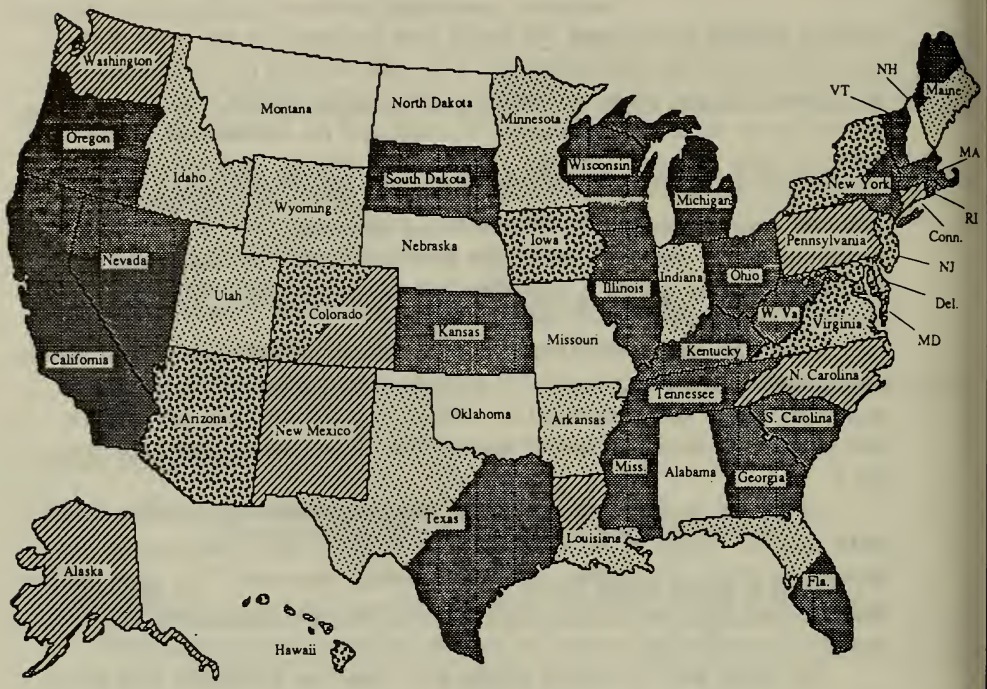
[47]Form reprinted by permission of the Society for the Right to Die.

[48]Society for the Right to Die, "How to Use the DIRECTIVE TO PHYSICIANS Authorized by the TEXAS NATURAL DEATH ACT," undated. Italics mine.

[49]Tex. Rev. Civ. Stat. Ann. art. 4590h-1, sect. 3 (Vernon Supp. 1991).

[50]Paul Premack, "Durable Power of Attorney for Health Care—Texas' New Legislation," *Texas Bar Journal* (September 1990): 861.

State Law Governing Durable Power of Attorney • Health Care Agents • Proxy Appointments •



Documents are available from the Society for states that clearly recognize an agent's power to have life support withheld or withdrawn.

Jurisdictions with Durable Power of Attorney statutes that permit agents to make medical decisions, specifically including decisions to withdraw or withhold life support (**California, Florida, Georgia, Illinois, Kansas, Kentucky, Maine, Massachusetts, Michigan, Mississippi, Nevada, New York, Ohio, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Vermont, West Virginia, Wisconsin and the District of Columbia**). The agent can act when the patient loses the ability to make his or her own medical decisions.

States with Durable Power of Attorney statutes that positively authorize consent to medical treatment, but do not specifically authorize the withdrawal or withholding of life support (**Alaska, Colorado, Connecticut, Louisiana, New Mexico, North Carolina, Pennsylvania and Washington**).

States with Durable Power of Attorney statutes that, through court decisions, Attorney Generals' Opinions or other statutes, have been interpreted to permit agents to make medical decisions, including those to withhold or withdraw life support (**Arizona, Colorado, Hawaii, Iowa, Maryland, New Jersey, New York and Virginia**).

States that authorize proxy appointments through their "living will" or "natural death" acts (**Arkansas, Delaware, Florida, Idaho, Indiana, Louisiana, Maine, Minnesota, Texas, Utah, Virginia and Wyoming**). Proxies are permitted to make decisions authorized by the act when the patient is in a medical condition covered by the act (usually "terminal" as defined in the act).

States with general Durable Power of Attorney statutes that make no mention of medical decisions.

Prepared by *Society for the Right to Die, 250 West 57th Street, New York, NY 10107 (212) 246-6973*

January 2, 1991

TEXAS
DURABLE POWER OF ATTORNEY FOR HEALTH CARE

INFORMATION CONCERNING THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all health care decisions for you in accordance with your wishes, including your religious and moral beliefs, when you are no longer capable of making them yourself. Because "health care" means any treatment, service, or procedure to maintain, diagnose, or treat your physical or mental condition, your agent has the power to make a broad range of health care decisions for you. Your agent may consent, refuse to consent, or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life-sustaining treatment. Your agent may not consent to voluntary inpatient mental health services, convulsive treatment, psychosurgery, or abortion. A physician must comply with your agent's instructions or allow you to be transferred to another physician.

Your agent's authority begins when your doctor certifies that you lack the capacity to make health care decisions.

Your agent is obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your agent has the same authority to make decisions about your health care as you would have had.

It is important that you discuss this document with your physician or other health care provider before you sign it to make sure that you understand the nature and range of decisions that may be made on your behalf. If you do not have a physician, you should talk with someone else who is knowledgeable about these issues and can answer your questions. You do not need a lawyer's assistance to complete this document, but if there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

The person you appoint as agent should be someone you know and trust. The person must be 18 years of age or older or a person under 18 years of age who has had the disabilities of minority removed. If you appoint your health or residential care provider (e.g., your physician or an employee of a home health agency, hospital, nursing home, or residential care home, other than a relative), that person has to choose between acting as your agent or as your health or residential care provider; the law does not permit a person to do both at the same time.

You should inform the person you appoint that you want the person to be your health care agent. You should discuss this document with your agent and your physician and give each a signed copy. You should indicate on the document itself the people and institutions who have signed copies. Your agent is not liable for health care decisions made in good faith on your behalf.

Even after you have signed this document, you have the right to make health care decisions for yourself as long as you are able to do so and treatment cannot be given to you or stopped over your objection. You have the right to revoke the authority granted to your agent by informing your agent or your health or residential care provider orally or in writing, or by your execution of a subsequent durable power of attorney for health care. Unless you state otherwise, your appointment of a spouse dissolves on divorce.

This document may not be changed or modified. If you want to make changes in the document, you must make an entirely new one.

You may wish to designate an alternate agent in the event that your agent is unwilling, unable, or ineligible to act as your agent. Any alternate agent you designate has the same authority to make health care decisions for you.

THIS POWER OF ATTORNEY IS NOT VALID UNLESS IT IS SIGNED IN THE PRESENCE OF TWO OR MORE QUALIFIED WITNESSES. THE FOLLOWING PERSONS MAY NOT ACT AS WITNESSES:

(1) the person you have designated as your agent;

(2) your health or residential care provider or an employee of your health or residential care provider;

(3) your spouse;

(4) your lawful heirs or beneficiaries named in your will or a deed; or

(5) creditors or persons who have a claim against you.

I have read and understood the contents of this disclosure statement.

_____ _____

(Signature) (Date)

Prepared by **Society for the Right to Die**
250 West 57 Street, New York, NY 10107 (212) 246-6973 0790

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

DESIGNATION OF HEALTH CARE AGENT.

I, _____ (insert your name) appoint:

Name: _____

Address: _____

_____ Phone: _____

as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document. This durable power of attorney for health care takes effect if I become unable to make my own health care decisions and this fact is certified in writing by my physician.

LIMITATIONS ON THE DECISION MAKING AUTHORITY OF MY AGENT ARE AS FOLLOWS:

_____

_____

_____

DESIGNATION OF ALTERNATE AGENT.

(You are not required to designate an alternate agent but you may do so. An alternate agent may make the same health care decisions as the designated agent if the designated agent is unable or unwilling to act as your agent. If the agent designated is your spouse, the designation is automatically revoked by law if your marriage is dissolved.)

If the person designated as my agent is unable or unwilling to make health care decisions for me, I designate the following persons to serve as my agent to make health care decisions for me as authorized by this document, who serve in the following order:

A. First Alternate Agent

Name: _____

Address: _____

_____ Phone: _____

B. Second Alternate Agent

Name: _____

Address: _____

_____ Phone: _____

The original of this document is kept at: _____

The following individuals or institutions have signed copies:

Name: _____

Address: _____

Name: _____

Address: _____

DURATION.

I understand that this power of attorney exists indefinitely from the date I execute this document unless I establish a shorter time or revoke the power of attorney. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my agent continues to exist until the time I become able to make health care decisions for myself.

(IF APPLICABLE) This power of attorney ends on the following date: _____

PRIOR DESIGNATIONS REVOKED.

I revoke any prior power of attorney for health care.

ACKNOWLEDGMENT OF DISCLOSURE STATEMENT.

I have been provided with a disclosure statement explaining the effect of this document. I have read and understood that information contained in the disclosure statement.

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY)

I sign my name to this durable power of attorney for health care on _____ day of _____ 19_____ at

_____
(City and State)

_____
(Signature)

_____
(Print Name)

STATEMENT OF WITNESSES.

I declare under penalty of perjury that the principal has identified himself or herself to me, that the principal signed or acknowledged this durable power of attorney in my presence, that I believe the principal to be of sound mind, that the principal has affirmed that the principal is aware of the nature of the document and is signing it voluntarily and free from duress, that the principal requested that I serve as witness to the principal's execution of this document, that I am not the person appointed as agent by this document, and that I am not a provider of health or residential care, an employee of a provider of health or residential care, the operator of a community care facility, or an employee of an operator of a health care facility.

I declare that I am not related to the principal by blood, marriage, or adoption and that to the best of my knowledge I am not entitled to any part of the estate of the principal on the death of the principal under a will or by operation of law.

Witness signature: _____

Print Name: _____ Date: _____

Address: _____

Witness signature: _____

Print Name: _____ Date: _____

Address: _____

and Rhode Island. In addition to proper execution, the Texas statute also requires that the power of attorney must be delivered to the agent before it becomes effective.

After the power of attorney is properly executed, witnessed, and delivered, the agent can make any medical decisions you could make for yourself, but only after the attending physician certifies in writing that you no longer have "the capacity to make health care decisions." Until the physician certifies this, the power of attorney sits dormant. When making decisions, the agent is required to act based on the *substituted judgment* standard, according to his or her knowledge of your wishes (including religious and moral beliefs). If the agent is not aware of your wishes, he or she is allowed to make a decision based on his or her assessment of your "best interest."[51]

There are two other important provisions in the Texas statute that apply to agents. Even though you are certified as "incapacitated" the physician is required to inform you of a proposed health care decision before the implementation of that decision. The Act requires that a treatment may *not* be given or withheld if you object *regardless of* the fact that the power of attorney exists and *regardless of* your lack of capacity. Ultimately, you retain a veto power over the physician and the agent, regardless of your mental state.[52] Another section of the Texas Act places a further limit on the agent's power. The agent may not place you into an inpatient mental health facility, may not authorize convulsive or psycho-surgical treatment, may not authorize abortion, and may not withhold "comfort" care.[53]

In the event there is already a court-appointed guardian, or one is appointed subsequent to the naming of an agent in a durable power of attorney, the agent will be removed in favor of the guardian in many cases. Also, if there is a conflict between the provisions of a Directive to Physicians and the durable power of attorney, the one signed later in time takes priority.[54]

D. Implications of Advanced Directives for Military Personnel

In a previous article,[55] I examined the Army Medical Department policies pertaining to the abatement of life-sustaining treatment.[56] These policies, which are still in effect, recognize the autonomous choice of all patients (military, retirees, and family members) in Army medical treatment facilities to make choices pertaining to life-sustaining treatment when they are either

[51]*Ibid.*, 862.

[52]*Ibid.*

[53]Tex. Act. art 4590h, sect. 2(f).

[54]*Ibid.*

[55]David M. DeDonato, "The Ethics of Dying: Difficult Choices in Army Medicine," *Military Chaplains' Review* (Spring 1989): 59-75.

[56]Department of the Army, *Army Regulation 40-3: Medical, Dental, and Veterinary Care*, chap. 19, "Do-Not-Resuscitate or 'No-Code' Orders," (Washington, D.C., 15 February 1985) and Department of the Army, Office of the Adjutant General, ATTN: DASG-PSQ, Washington, D.C. Letter, dtd. 30 August 1985, Subject: Withdrawal of Life-Sustaining Treatment.

terminally-ill or in a persistent vegetative state.[57] Procedures are established for a surrogate to make "substituted judgment" decisions when the patient lacks decision making capacity (is incompetent). This would appear to ensure that the autonomy of the patient would be protected. However, some words of caution are appropriate.

While living wills are not mentioned by name in the DNR regulation, it is acknowledged that "patients may have made firm and explicit verbal and written directives regarding the decision [for or against resuscitation]." The existence of these directives, however, is no guarantee that the provisions will be carried out by the attending physician. While "such directives should be discussed with the NOK or legal guardian and should be honored," their provisions could be ignored if "there is reason to believe that the patient's choice has changed or would change."[58] The policy letter pertaining to withdrawal of life-sustaining treatment contains no mention of written advanced directives that would be executed by the patient prior to admission as an inpatient. Only a verbal statement by a *competent person* while an inpatient is indicated as the only accepted means of consent or refusal of life-sustaining treatment.[59]

It appears that the surrogate, be it the next of kin or the legal guardian ("durable power of attorney for health care" has not been added to the wording of either policy), has the authority to speak on behalf of the incompetent patient to make life-sustaining treatment decisions. But what happens if the surrogate and the attending physician disagree on a particular treatment decision? Both policies provide for the convening of an ethics panel which "exists for the patient" and will "help resolve the problem if there is a lack of concurrence by the treating physicians, or members of the family among themselves or with the treating physician."[60]

This provision, on the surface, appears to be a safeguard for resolving these matters; the reality is that ethics committees are not the preferred means for physicians to resolve these impasses. Many physicians resist approaching a multidisciplinary body to resolve disagreements between the surrogate and the physician. This is an example of the *autonomy-beneficience* tension mentioned earlier. My experience has been that the usual method of dealing with this type of dilemma is for the physician to *maintain the status quo* by continuing to treat the patient until the surrogate changes his or her mind *or* the patient dies. Is that acting in the patient's best interest?

IV. Conclusion

Of the many reasons for military members, retirees, and their family members to execute advanced directives the most compelling one is that it ensures that

[57]Other military services also have similar guidelines:

Department of the Air Force, HQ USAF/SG Policy Letter, Management of Terminally Ill Patients, 21 July 1982.

Department of the Navy, Naval Medical Command, NAVMEDCOM INSTRUCTION 6320.2, Subj: Guidelines for orders not to resuscitate, 23 November 1983.

[58]AR 40-3, paragraph 19-7a.

[59]The Surgeon General's Letter, para. 4a.

[60]AR 40-3, para. 19-2g. Similar wording is found in The Surgeon General's Letter, para. 2i.

any physician, military or civilian, as well as family members have knowledge of their wishes. This can, in turn, lead to meaningful discussion of these choices with the parties who may have to implement them. Now that living wills can be filed in health records, outpatient treatment records, and inpatient treatment records at Army medical treatment facilities,[61] the system can be more effectively utilized to protect patient autonomy. The other military services have similar provisions built into their local hospital's policies.[62]

There is a growing realization that medical technology has limits to what it can accomplish. The vision of existing during their last days in great pain and discomfort, with feeding tubes, wires and IVs protruding from their limbs, is not how many people visualize their death. Yet, that scenario is a real possibility given our ever-lengthening life span and medicine's driving need, and society's desire, to heal and preserve life at all costs. Many persons are sensing that there is a right and preferred way of dying and a time in each person's life when he or she says, "enough is enough, let me die in peace."

As pastors and carers we should be concerned about all aspects of our people's lives—physical, mental, emotional, and spiritual. Making a decision as to what limits to place on the quality of life we will live in our final years is an intensely personal choice. To help facilitate these decisions, we have an obligation to those who come to us for guidance to listen to them and to raise their awareness of the choices that are rightfully their's to make. It is hoped that this article will provide you with some information that will make your task and their's much easier.

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[61]Department of the Army, Office of the Surgeon General, ATTN: SGPS-PSA, Washington, D.C., Memorandum, dtd 9 November 1990, Subject: Placement of Living Wills in Outpatient Treatment Records, Health Records, and Inpatient Treatment Records.

[62]One example is Department of the Air Force, Wilford Hall Air Force Medical Center, *Medical Regulation 160-42: Management of Terminally Ill Patients*, (Lackland Air Force Base, TX, 24 July 1990).

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Appendix A

Medical Ethics and the Health Care Provider Team on the Battlefield Conference

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*Compiled by Chaplain (LTC) David M. DeDonato, Chief, Clinical Chaplaincy Branch, Academy of Health Sciences, U.S. Army, Fort Sam Houston, Texas, who served as Conference project officer.

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Appendix B

Health Care Ethics Resources*

General Medical Ethics & Clinical Ethics

Beauchamp, Tom L. and Childress, James F. *Principles of Biomedical Ethics.* 3d ed. New York: Oxford University Press, 1989.

[One of the classics. The first two chapters are difficult reading. After that, it gives you an excellent overview of bioethics.]

Jonsen, Albert R., Siegler, Mark and Winslade, William J. *Clinical Ethics.* 2d ed. New York: Macmillan Publishing Co., 1986.

[If you are directly engaged in patient health care or ministry, this book is a must! It begins with patient cases and presents the bioethical implications in a quick, easy to read format. Cross-reference index.]

Medical Ethics: A Guide for Health Professionals. Edited by John F. Monagle and David C. Thomasma. Rockville, MD: Aspen, 1988.

[Outstanding presentation of contemporary bioethical issues - AIDS, organ transplants, genetic engineering, etc.]

Basic Clinical Ethics and Health Care Law. Edited by John C. Fletcher. Charlottesville, VA: Ibis Publishing, 1990.

Background Readings to above (3-ring binder).

[Both of the above were created by the teaching team of a course in medical ethics at the University of Virginia that began in 1987. Very useful for any health care professional, ethics committee member, or family member who is concerned with ethical and legal issues in the care of patients.]

Medical Ethics For Physicians

Beauchamp, Tom L. and McCullough, Laurence B. *Medical Ethics: The Moral Responsibility of Physicians.* Englewood Cliffs, NJ; Prentice Hall, 1984.

Nursing Ethics

Ethical Issues in Nursing. Edited by Peggy L. Chinn. Rockville, MD: Aspen Systems, 1986.

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Ethics at the Bedside. Edited by Fowler & Levine-Ariff. J.B. Lippincott, 1987.

[This book is for critical care nurses. An excellent handbook that gets right to the heart of bioethical issues in the ICU.]

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*Complied by Chaplain (MAJ) Dave DeDonato, Chief, Clinical Chaplaincy Branch, Academy of Health Sciences, U.S. Army, Fort Sam Houston, Texas, who is an instructor in health care ethics.

Health Care Ethics For Administrators

Health Care Ethics: A Guide for Decision Makers. Edited by Gary R. Anderson and Valerie A. Glesnes-Anderson. Rockville, MD: Aspen Publishers, 1987.

[A good companion to Monagle & Thomasma's *Medical Ethics: A Guide for Health Care Professionals.* This is geared for the hospital administrator. Major headings include: Framework for Thinking, Access to Health Care, Termination of Treatment, The Right to Know, Professional Management Issues, et. al. Articles present a multidisciplinary look at these issues.]

Ethics for Health Services Managers. Edited by Kurt Darr. Health Administration Press, 1985.

[This book also contains case studies relating to bioethical issues in hospital administration.]

Medical Ethics In Emergency Medicine

Iserson Kenneth V., Sanders, Arthur B., and Mathieu, Deborah R. *Ethics in Emergency Medicine.* Baltimore: Williams & Wilkins, 1986.

[An excellent source that dispels the myth that dilemmas in emergency medicine are exceptions to normal bioethical rules. Differences in emergency medicine and regular medical care are recognized, however, specific ethical dilemmas in the ER and some suggested solutions are offered. Of great value is an ethical decision making model for ER personnel.]

Religion and Health Care Ethics

On Moral Medicine: Theological Perspectives in Medical Ethics. Edited by Stephen F. Lammers and Allen Verhey. Grand Rapids, MI: William B. Eerdmans Publishing Co., 1987.

[This is an anthology of essays that focus on the theological aspects of medicine and the troubling moral issues that often surround medicine. Some issues are: health and healing, death and its (in)dignity, care of patients and their suffering, contraception, technological reproduction, the physician-patient relationship, and care of neonates.]

Health and Medicine in Faith Traditions series. Various authors. Crossroad Publishing. Available through the Park Ridge Center.

Current titles in this series are: Health & Medicine in the Methodist, Lutheran, Anglican, Jewish, Catholic, Reformed, Islamic Tradition. **Future titles**: Christian Science, Eastern Orthodox, Hindu, Native American, Seventh-Day Adventist, Mormon, Evangelical, Secular Humanist.]

Ashley, Benedict M. and O'Rourke, Kevin D. *Health Care Ethics: A Theological Analysis* 2d ed. St. Louis: Catholic Health Association of the United States, 1982.

[The classic for Roman Catholic health care ethics.]

Rosner, Fred. *Modern Medicine and Jewish Ethics* New York: Yeshiva University Press, 1986.

[An outstanding contemporary reference for Jewish health care ethics.]

Health Care Ethics Case Studies

Cases in Bioethics From the Hastings Center Report. Edited by Carol Levine. Rev ed. New York: St. Martin's Press, 1989.

Freeman, John Mark and McDonnell, Kevin. *A Casebook in Medial Ethics*. New York: Oxford University Press, 1987.

Multi-Cultural Views of Health Care Ethics

Veatch, Robert M. *Cross Cultural Perspectives in Medical Ethics: Readings*. Boston: Jones and Bartlett Publishers, 1989.

[Compilation of foundational documents of various cultures which address key ethical principles and their application to medical ethical issues. Eastern European, Soviet, Chinese, Islamic, and ancient Indian sources are quoted. Main shortcoming of this book is that it doesn't address *how* these perspectives impact on patient care.]

The Western Journal of Medicine, *Cross-Cultural Medicine*, 139, no. 6 (December 1983).

[The reprint of this special issue addresses how the cultural views of Philpinos, Black Americans, Japanese, Southeast Asians, Jamacians, Pacific Islanders, Middle Easterners, Chinese, Latinos, and Soviets influence health care decisions made on behalf of these types of patients. Most of the chapters include a section on ethical considerations.]

Health Care Law

Macdonald, Michael G., Meyer, Kathryn C., and Essig, Beth. *Health Care Law: A Practical Guide*. New York: Matthew Bender & Co., Inc., 1990.

[Probably the best health care law book on the market. Comes in a binder that allows you to insert the yearly updates of changes in health care law.]

Southwick, Arthur F. *The Law of Hospital and Health Care Administration*. 2d ed. Ann Arbor, MI: Health Administration Press, 1988.

[Covers much of the same material as the Macdonald book. Is not as expensive as the book but does not provide updates. A good textbook for an overall look at law and the American legal system and the various aspects of health care law that remain constant.]

Medical Ethics Encyclopedia and Dictionary

[Both of the following are available from the Kennedy Institute of Ethics through the membership office. Price reduction for members.]

Encyclopedia of Bioethics. Edited by Warren T. Reich. 4 vols. New York: Macmillan-Free Press, 1982 reprint.

Dictionary of Medical Ethics. Edited by A.S. Duncan, G.R. Dunstan, and R.B. Welborn. New revised edition. New York: Crossroad, 1981.

Bibliographies

Bibliography of Bioethics. Edited by LeRoy Walters and Tamar Joy Kahn. Washington, DC: Kennedy Institute of Ethics, Georgetown University. Issued annually since 1975.

[This corresponds to the BIOETHICSLINE database listed below.]

Online Computer Database

BIOETHICSLINE. Produced by the Kennedy Institute of Ethics for the National Library of Medicine. Searchable through the MEDLARS system. For information on securing a personal access code from the National Library of Medicine, call (800) 638-8480. Prime time average $24/hr. Non-prime time $17/hr. No minimum usage fee. First $40 is free.

AIDS

Shelp, Earl, E. *AIDS: Personal Stories in Pastoral Perspective*. New York: Pilgrim Press, 1986.

AIDS: Issues in Religion, Ethics, and Care. A Park Ridge Center Bibliography. Compiled by Kathleen A. Cahalan, 1988. 130 pp.

Abatement of Life-Sustaining Treatment

Hastings Center. *Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying*. Briarcliff Manor, NY: The Hastings Center, 1987.

Casebook to the above-listed reference.

[The two references listed above are the standard for life-sustaining treatment health care ethics issues. Highly recommended.]

Institutional Ethics Committees/Ethics Consultation

Institutional Ethics Committees and Health Care Decision Making. Edited by Ronald E. Cranford and A. Edward Doudrea. Ann Arbor, MI: Health Administration Press, 1984.

Ethics Consultation in Health Care. Edited by John C. Fletcher, Norman Quist and Albert R. Jonsen. Ann Arbor, MI: Health Administration Press, 1989.

Culver, Charles M. *Ethics at the Bedside*. Hanover, NH: University Press of New England, 1990.

[Outstanding book for examples of ethical consultation at work. Twelve scenarios describe how moral decisions are made in modern hospitals. The potentially helpful process of ethics consultation offered at many hospitals is also outlined.]

Human Experimentation

Veatch, Robert M. *The Patient as Partner: A Theory of Human Experimentation Ethics*. Bloomington, IN: Indiana University Press, 1987.

Health Care Ethics Organizations

KENNEDY INSTITUTE OF ETHICS. Georgetown University, Washington, DC 20057. (800) 633-3849. $55/yr. for associate membership. $175/yr. for institutional memberships available. Members receive the following periodicals:

Kennedy Institute Newsletter. Bi-monthly 4-page report of Kennedy Institute news and essays on current health care ethics subjects.

New Titles in Bioethics. A monthly 5-7 page up-to-date survey of books, government documents and publications in health care ethics.

Scope Notes Series. Ten to 15-page overviews of current health care ethics topics.

THE HASTINGS CENTER. Institute of Society, Ethics, and the Life Sciences, 255 Elm Road, Briarcliff Manor, NY 10510. (914) 762-8500. $46/yr. for associate membership. $60/yr. for institutional memberships and libraries. Members receive the following periodical:

The Hastings Center Report. A bi-monthly journal of essays and case studies on current health care ethics subjects.

THE PARK RIDGE CENTER. Membership Division, P.O. Box 1347, Elmhurst, IL 60126. (312) 266-2222. $35/yr. for associate or institutional membership. Members receive the following periodicals:

Bulletin of the Park Ridge Center. Published in January, May, and September. Presents accessible, useful information in fields related to health, faith, and ethics.

Second Opinion. Published in March, July, and November. Interdisciplinary essays in fields related to health, faith, and ethics.

Health Care Ethics Periodicals

(Also, see listings under HEALTH CARE ETHICS ORGANIZATIONS)

Bioethics. 3 Cambridge Center, Cambridge, MA 02142. $49/yr. for individual subscriptions, $103.75/yr. for institutional subscriptions.

HEC Forum (Hospital Ethics Committee Forum). Pergamon Press, Fairview Park, Elmsford, NY 10523. $25/yr. for individual subscriptions, $50/yr. for institutional subscriptions.

Hospital Ethics. American Hospital Association, 840, N. Lakeshore Dr., Chicago, IL 60611. $85/yr. for AHA members, $135/yr. for non-members.

Journal of Medicine and Philosophy. Box 358, Accord St., Hainham, MA 02018. $41/yr. for Kennedy Institute members, $47/yr. for non-members.

Journal of Medical Ethics. Professional and Scientific Publications, British Medical Journal, Box 560B, Kennebunkport, ME 04046. $85/yr.

The Journal of Clinical Ethics. 107 East Church St., Frederick, MD 21701. $55/yr. for individual subscriptions, $95/yr. for institutional subscriptions.

The Interruption

Melvin G. Brinkley

"Then they said, 'Come let us build ourselves a city, with a tower that reaches to the heaven, so that we may make a name for ourselves, and not be scattered over the face of the whole earth.'" (Genesis 11:4)

Friday is catch-up day and this was definitely Friday. I plodded up my tower's stairway of things done. Each step brought me the satisfaction of climbing higher, getting somewhere, doing something. At the end of my ascent, I looked out briefly on the horizon and then started to build with the materials of that day. I bought pizza and Cokes, the essential elements of existence for the youth, from the commissary that morning. I reserved the roller skating rink for this Sunday's Junior Teen outing, I attended the First Sergeants' weekly meeting to get the

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Chaplain, Captain, Melvin C. Brinkley is assigned as the Religious Education Chaplain at K.I. Sawyer AFB, Michigan. He is a graduate of the University of Virginia, and received his M.Div. from Emory University, Atlanta, Georgia. He is a United Methodist Clergyman.

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ball rolling on selling tickets for the National Prayer Breakfast. I called the NCO Club and made the arrangements for the Passover menu. I then phoned the Jewish Lay Leader and informed him of the latest changes. I reviewed the calendar and noticed the Caribbean Luncheon, an ethnic outreach endeavor, would have to be rescheduled because it conflicted with the Lenten Luncheon. The Catholics had warned me about the menu for the Caribbeans. Since most of the Island folks were Catholic, it must be fish if it was on a Friday during Lent. I checked with the deli at the Commissary to see what they could fix for us. They told me they did not carry fresh fish. Frozen would have to do. The sermon for this Sunday definitely needed some more work today if I was going to have Saturday relatively free for the family.

I was piling brick upon brick; building my lofty tower skyward in order to make a name for myself. It wasn't that I expected people to remember my name a hundred years from now, or see my name in lights, or mentioned on a talk show. All I really wanted was to be accepted by the community I worked with, and assured that I had made a difference. I needed tangible evidence that I had made a positive contribution. This structure of programs, people, places, and minutiae gave me better sightings on the periphery. It was invigorating and sometimes even intoxicating to stare down below and see just how far I had come; but then, when I looked off into the heavens I realized that the ground was not that far off.

If I could only reach an impressive height, then I would no longer mind the smug smiles of those more experienced than I having the approval of admirers. My tower would be impregnable. I knew that it would take my all to maintain this structure and only felt a slight irritation knowing that the task would never be finished. I realized that at the end of my time on earth I would have to abandon it, but I pushed that thought away. A few positive remarks, some compliments scattered here and there, and a sprinkling of applause was what held this tower together. As a new chaplain in the Air Force I wanted the assurance that I was going upward. I had found a way to unite all my energies and ambitions in the building of an edifice dedicated to me.

The buzzer rang in my office. It was the secretary. Someone wanted me for something. I had too much to do to be bothered, but I needed to be needed and felt good about my busy-ness.

"Chaplain Brinkley?" the voice on the line questioned. "This is the nursing station of the OB/GYN Ward."

"Yes?" I asked.

"Could you come to the hospital? I think you could help us."

"I plan to come over today anyway. What is the problem?" I asked, noticing the time and regretting that most of the morning was gone.

"A woman had a spontaneous abortion last night."

"A stillbirth?"

"Well, yes, that's another name for it."

"So the baby or fetus is dead."

"Yes. The fetus was rejected by the womb because of an infection and other complications."

"How is the mother doing?"

"She's still sedated but I'm sure her husband could use a visit."

"I'll be over this morning as soon as I can."

"Thanks," the voice on the line said and hung up.

"Hmmm," just a few loose ends to tie up and then I will do my hospital visitation. I will see this woman first, though. In a way, I was happy for the break. I had been in the office too long and I was getting tired of the continual changing of menus for this or that ethnic or religious group. Some of the projects were stale and flat from the daily chewing and rehashing. I needed a new opportunity to prove myself. I thought that even this visit to the hospital and rescuing someone in distress might be a way of adding another brick to my tower. I left the chapel feeling good about the progress of some of my projects.

On the way to the hospital I went over my checklist. This visit could require a great deal of time and follow-up and, therefore, was one detail too much. My inner voice whispered to me, "I'll be glad when I take leave next week."

I thought back to my past visits to the hospital with a measure of assurance. My daily encounters with the hospital patients had for the most part been cordial. This one could be very different and that was a little disturbing. I assumed the woman would be in the OB/GYN ward since the nurse called me from that station. The nurses there were friendly and helpful. They liked calling me Padre or Father, asking me to do something about the weather, since snow and ice seemed to be our only two seasons in the Upper Peninsula of Michigan. I would chuckle and assure them they were addressing the right person since I had high connections.

Father Ron gave tootsie-pops to the patients and hospital staff when he visited. Since I had been reassigned as the hospital chaplain, I was there a lot. All chaplains must look alike to hospital patients because they expected me to give out tootsie-pops, too. In order for them to tell the difference between me and Father Ron, I started giving out Hershey Kisses. If people could not tell one chaplain from the other maybe something more important like candy would separate our identities. I liked to flirt with the female nurses. "Would you like a kiss?" In the split second of their shock, I would hand them the chocolate variety. So far, I had not been slapped. The male nurses were given kisses, also, and their reaction was even more rewarding. The hospital staff was beginning to know me by my name. It was worth a ton of chocolate kisses to be called by my name instead of being called the generic: "chaplain."

As I entered the OB/GYN Ward, I looked for Nurse Crystal. She seemed to always have time for my questions about patients.

"Time for your medication!" I smiled as I handed her a silver kiss.

"A chocolate a day helps keep the boyfriends away but I'll take one anyway," she sang back. She liked to sing or hum as she worked. She was always pleasant to be around.

"How have you been?"

"Busy, busy, busybusybusy," she buzzed.

"Do you know anything about a patient that had a stillbirth last night?"

"Yes. The lady was moved to the Med/Surg ward. Her name is McCain, Ruth McCain. This is not the first time this has happened to her. She's a nurse, by the way. She works in Marquette."

"She's a nurse! I hear that doctors make lousy patients. How about nurses?"

"We make the best patients, of course," she huffed with mock righteous indignation.

"We will see about that," I hissed with faked smugness.

"I'm glad you are going to see her. She needs support."

"Well, I'll visit around while I'm here. You say this is not the first time she's had a stillbirth?"

"She has a history of this sort of thing, oh, for the past couple of years."

"Thanks for the info."

As I walked down the hall I tried to mentally and emotionally prepare myself to face what must be a painful loss for both of the parents who had lost the baby or fetus. I still did not know what to call it. It? The life inside her had been a potential person. The word "it" did not sound right. I tried to realize the impact of what the OB/GYN nurse had said about this woman. She had lost a life inside her. She had lost a life that began inside her. Someone had died inside of her. A baby? The nurse on the phone had called it a fetus. A person? For some reason I kept on methodically walking towards the patient's room. I did not have a plan or a rehearsed first sentence. I did not stop to review the stages of grief or what some professor had said to do when this happens. I did not slow down. I kept walking, pushed along by the momentum of all those things that had a claim on this day. I had to do this. A sneaky thought crept in, "I hope she is still sedated. Then I can leave my card and go."

A nurse was in the Med-Surg nurses' station. "Is it OK if I visit Mrs. McCain?" I asked.

"Yes, she's still a little groggy, but she can understand what you say."

There would not be an escape. I would have to face her. I had heard clergy glibly call such hospital visits as this one an "opportunity" for ministry, meaning that some things have to be done, regardless. There was also no way to plot a course of what to say. With no prepared speeches, I felt naked. This was more than any little seminar on death and dying could train anybody to handle successfully. I felt angry and frustrated at the absence of assurance. I did not want to be there but I was supposed to be there.

I came in. I noticed the chair in the lime green room was empty. The sky was gray and cold. It looked like it would snow, again. Winter was the only season my memory could summon in spite of the great need to grasp another season. I turned away from the window. The bed next to the door was in sight. The outline of legs under the sheets came into view as I turned the corner. The privacy screen was halfway closed blocking my view of Mrs. McCain. A nurse hunched over a machine. I stood at the curtain and waited but no one noticed my presence. I cleared my throat and asked if I could come in. The nurse nodded without looking up or stopping whatever she was

doing with the machine. I then slowly pulled the curtain open. Ruth McCain lay before me in pure white. Her coffee brown skin was framed by the sterile sheets. The machine that hid behind the nurse clicked with the monotony of a metronome, marking the time, empty and anxious. The nurse turned her head and spoke in a whisper, assuring me I could visit and that Ruth could understand. She then slipped out the door. I stepped forward. I smiled weakly trying to show courage, fully knowing I was helpless.

Her eyes were streaked with red. Those eyes looked angry and I knew why. I thought of my own children. They are so dear. To lose one of them would be like dying, like losing a part of myself, my marriage. Her eyes were now focused on me and on the cross I wore. God have mercy on this woman. God have mercy on us all. A life had been lost. Who would answer for this? Me? She looked from my eyes to the cross and back again. This scene was all too familiar. How many times had I held a person's hand while balancing the topics of death and God's love? How many times had I represented God and wondered if I believed in the words of comfort that poured out. In a perverse sense, I wanted someone to scream, to hit something, to tear something apart, to curse something, but there was only silence and softness. No one showed anger. Ruth held the pain in. Maybe she felt that nurses should be good patients and not make trouble. Maybe she was tearing herself up from the inside. No one said anything. The room felt close and I wanted something to fill the emptiness other than the machines that seemed to mock us. Someone should be outraged but all was numbness.

"Is it OK if I visit with you? I'm Chaplain Brinkley." She said nothing. "I heard that you might need a visit."

Her large brown eyes were moist. Pools of tears swelled at the bottom of her eyes but nothing trickled down her cheek. Her mouth quivered but no words came. I pressed my lips together hard and gritted my teeth. The enormity of her loss was slowly sinking in.

"You've been up all night, haven't you?" I stammered.

"Yes," in the softest of whispers.

"I'll come back and see you when you feel more like talking. You are in a lot of pain, I'm sure." She said nothing. She did not excuse me. I would have to continue. My thin ploy to gain time and distance from this painful room did not work. A millennium passed. The machines measured time in rhythmic beats and then the faintest voice whispered out of the emptiness, "Ask her what the child's name is." The voice was not audible. I did not see a vision. I was not a candidate for sainthood or sanitariums. I had simply run out of any other option to talk about or maybe the voice came from a source beyond me. I had never asked such a question before. Peace came with this suggestion. I cannot claim that insight as mine but I was grateful for its company. The tenseness of the room drained away. I could breathe. I gently grasped the content of that gift. This was what I was missing. This was what was needed. This was the balm for our souls. In an instant I knew that the naming of the dead baby would be the beginning of healing. The name the mother would give to this unborn child would be the name of her anguish. She would no longer be plagued by a vague sense of loss but would

be empowered by addressing this loss by its name. Ruth's pain had come out of the shadows as God asked for its name.

"What was the name of your baby?"

"Daniel," she smiled bitterly. The noise of the machines faded. In that moment I reached for her hand. We touched. It was a moment of encounters. Pain and peace, the Holy and the profane, met in one great instant. I was free from relying on my own ingenuity. The peace of assurance was in the room. Reaching had ceased. I had been silenced. The piling up of things and events had ended and chaos had been pushed aside. My struggle to be looked at and to be noticed stopped. The tower crumbled. The walls disappeared as if they had been vapor instead of brick. Her hand was warm and strong. God had spoken through this mother's pain. Listening to that life-giving voice made me realize how dead I had been.

We prayed for Daniel but the contents of that prayer are lost to me now. I thought as I left her room that I had done a rather non-Protestant thing, praying for the dead; but surely we do that in our memorial services and church homecoming celebrations, I rationalized. I remembered many a dedication service where a building or a stained glass window was given in memory of a loved one and that loved one's name permanently affixed to a bronze plaque. The naming of this baby was a way of touching a person that never had the chance to be held by their mother. Mrs. McCain's pain eased if but for a moment. I left her room recognizing the Holy and realizing how long it had been since I had been in conversation with God; real dialogue, not just spouting words into emptiness, but actually hearing and understanding what was said to me. That precious moment was a banquet for a starving soul; me. God finally answered a prayer the way I had always wanted it to be answered; immediately and clearly. Perhaps I was able to hear because I had nothing more to say.

Book Reviews

Songs of My Soul: Devotional Thoughts from the Writings of W. Phillip Keller

Compiled and Edited by Al Bryant

Word Publishing, 1989, 251 pages.

Al Bryant is the author/compiler of more than 50 books, including several other devotionals based on the writings of Charles Haddon Spurgeon, Andrew Murray, and John Wesley.

Songs of My Soul is a daily devotional guide compiled and edited by Al Bryant from the works of W. Phillip Keller, who is best known for his book *A Shepherd Takes a Look at the 23rd Psalm*.

The book has a title index, a subject index, and scriptural references which are in sequential order from Genesis 1:2 on January 1st, to Revelation 3:21 on December 31st. Such organization makes the book easy to use as a resource in sermon preparation.

However, as with many daily devotional guides of this type, when sections are extracted from full-length works, the daily piece may be incomplete, fragmented, or not fully related to the scripture text. Selected paragraphs from a chapter do not necessarily complete a thought in the same way as devotionals which have been intentionally written as such. When, on the other hand, the devotions in this book are complete within themselves they are frequently inspirational and sometimes even seem specifically written as daily devotions. Unfortunately, except for the presence of some beautiful images from nature, the majority of the selections seem to lack luster.

I would not recommend the book unless you were a solid fan of W. Phillip Keller. Even then, W. Phillip Keller is better read in context as are Thomas Merton, John Wesley, and many others of whom such devotionals have been compiled. Better devotionals written specifically for daily use are readily available such as *Portals of Prayer, Daily Bread, or Daily Guideposts 1990* (annually published).

Chaplain (CPT) David R. Brook
U.S. Army

Commitment: Key to Christian Maturity

Susan Muto and Adrian van Kaam

Paulist Press, New York, 1989, Paperback, 216 pages.

Dr. Muto holds her Ph.D. in English literature from University of Pittsburgh and is Director of the Institute of Formative Spirituality at Duquense University. Dr. van Kaam holds his Ph.D. in psychology from Case Western, Cleveland and is Director Emeritus of the Institute of Formative Spirituality and professor of Foundational Formation. Dr.'s Muto and van Kaam have separately authored many books, conducted seminars, workshops, and conferences both in the United States and abroad.

I was excited to get this book, seeking direction to experience a growth in my personal commitment in Christian maturity. I read the cover and then looked at the bibliography. I know that is strange, but I like to know the references used. There are 7 pages of bibliography! As my excitement grew, I looked at the table of contents and discovered a 5 1/2 page, in-depth outline of how the authors were going to explain their idea of COMMITMENT: KEY TO CHRISTIAN MATURITY or Discovering God through Faithfulness to our Daily Commitments.

I began reading only to discover that the authors had devised too great an outline for such a small book. Each sub-chapter had an average of three pages and some were redundant of previous sub-chapters and even of previous chapters. The outline showed great potential, however the research deserved to be expanded.

I did not gather a lot in my desire for growth, Christian maturity, discovering God, faithfulness, or daily commitments. The underlying theme of the book is "call," "unique individual," and the "Divine Mystery." This was especially noticeable in Part Two - Commitment and the Threefold Path. (In 36 pages, there are 4 chapters and 19 subchapters).

The authors present a weak argument concerning the threefold path and spend entirely too much time attempting to prove the validity of, rather than the commitment to obedience, poverty, and chastity/charity/love. There is very little on commitment in the argument and even less on a Christian maturity.

Part 3: Love and Commitment; Chapter 9: Romantic Love - Prelude to Committed Love begins with the sentence "Some of us may experience at certain moments the heady experience of romantic love." (p 71) The phrase "heady experience of romantic love" is never explained and for 10 pages the authors want to move beyond simplistic love to a mature and committed love. However, they cannot get away from the fact that a mature, committed love really is romantic - although not simplistic.

And so it was throughout the book. There were only a handful of quotes with reference noted, even though there is the 7 page bibliography. I got the impression that the authors wanted to do a lot, but keep it in a small package. It would have been better had they chosen only 2 major areas of commitment (Part 1 "Living Commitment" and Part 3 "Love and Commit-

ment"), kept their 9 chapters, and given more study and application to their thesis in these two areas alone. By doing this, they could publish 3 books of the same length and actually lead people in their Christian maturity called commitment.

Chaplain (CPT) Allen K. Lowe
U.S. Army

Health Care Ministry: A Handbook for Chaplains

Helen Hayes, O.S.F. and Cornelius J. van der Poel, C.S.Sp., editors.

Paulist Press, 1990, Soft, 191 pages, $9.95.

Sr. Helen Hayes, O.S.F. is Executive Director of the National Association of Catholic Chaplains. Rev. Cornelius J. van der Poel, C.S.Sp., is a Counselor and Spiritual Director at Ecclesia Center in Erie, Pennsylvania.

The National Association of Catholic Chaplains (NACC) saw the need to provide a broad-based contemporary unified work for Catholics to consult as an introduction to themes of pastoral health care. This work does that. It also serves as an excellent introduction for non-Catholics. The forward describes the book as an "edited sourcebook in health care ministry." Chapters are written by those with special training or experience with the treated topic. The issues addressed are important to all who provide for the religious/spiritual needs of patients and personnel in a hospital.

The book provides fifteen papers in three sections. The first section, "General Considerations," addresses a theology of pastoral care, ethical decision making, professionalism in the chaplaincy, and marketing pastoral care. The second section, "Pastoral Service," looks at pastoral care administration, quality assurance, rehabilitation, mental health, care of the aging, health care in the parish, and general health care ministry. The last section, "Pastoral Education," treats Clinical Pastoral Education, pastoral counseling in the health care setting, certification and accreditation issues for pastoral care departments.

All topics are clearly presented and important to health care ministry. Some of them are new to the hospital ministry agenda. These are rapidly becoming very important to the future of such ministry. In this era of empiricism which requires increasing skill in demonstrating how one contributes to the mission of the organization/hospital, issues such as quality assurance, certification, accreditation, and the marketing of pastoral care are rapidly emerging as crucial to the survival of pastoral care departments. Interest in these issues will benefit religious support efforts in other organizations as well.

Reading this book will certainly be of help to those involved in health care ministry. It can help practitioners evaluate their present programs and strengthen or improve the delivery and image of pastoral care departments. Each of the chapters has helpful suggestions for further reading. The Na-

tional Association of Catholic Chaplains has provided a helpful book for all of us. Those involved in areas of ministry other than health care settings are limited only by their insight as to ways of applying issues addressed by these authors to other religious support settings.

Chaplain (MAJ) Kenneth M. Ruppar
U.S. Army

A Church of the Baptized

Rémi Parent

Paulist Press, 1989 (English translation), Soft cover, 213 pages, $12.95.

Dr. Rémi Parent is presently a member of the theology faculty at the University of Montreal. He holds a doctorate in theology from the prestigious University of Lyons, France. The author of numerous articles and books, Dr. Parent is a sought after presenter at theological and pastoral conferences worldwide.

What is the future of the laity in the Catholic Church? What is it they feel prevents them from attaining their "most legitimate aspirations." Attention must turn to the relations that are operative between the clergy and the laity.

Clerics and lay people refer to a type of relation that makes each cleric or lay person exist as clerics and lay people. The future of cleric and lay person requires that each cease "being" in the traditional sense we have known them - without a predefined identity. They must open up to new ways of a common ecclesiastical life.

There are three levels to this problem. The first is the difficulty that is experienced between clerics and lay people on a functioning level. There is a need to improve the functioning of the organization. The second level makes the issue larger by its revelation that the ecclesiastical structure of clergy/laity relations must be challenged. The third level asks the disquieting question - Can we "re-think" the terms of clergy and laity differently?

Defined by the present relationships with clerics, lay people have no future because they do not have an ecclesiastical present. One must now invite the thesis posed throughout the book - "those who continue to be called lay people do not have an ecclesiastical future; they are the future of the church. The future of the church belongs to "all those who, wedding the future of God with the future of the world in their decisions, truly assume their status as subjects of life in the church."

A Church of the Baptized is a thoughtful insight into the heart of laity tensions. It challenges our way of "functioning" as clerics and laity. It leads us to examine the "structure" we place in the body of Christ. It asks the penetrating question - Can we think of the clergy and laity differently, organizing our relationship in a new way within the structure we find ourselves?

Chaplain (CPT) Charles M. Herring
U.S. Army

Bioethics Today: A New Ethical Vision

James W. Walters, Editor

Loma Linda University Press, [Loma Linda, CA 92350], 1988 ,Paper, 116 pages.

This book is a publication of the newly created Ethics Center of Loma Linda University. It consists of nine papers first presented at a 1985 conference in biomedical ethics. The nine contributors include: Daniel Callahan, director and co-founder of the Hastings Center and author of more than 22 books and 200 articles; Roy Branson, Senior Research Scholar at the Kennedy Institute of Ethics, Georgetown University; and Arthur L. Caplan, Director of the Center for Biomedical Ethics at the University of Minnesota.

In the first essay, Callahan suggests that the ethical questions of today challenge the basic traditions of medical ethics, Western philosophy and the fundamental values of Judeo-Christian tradition. He suggests that a fundamental biomedical ethical question of today is whether or not: ". . . medicine can keep people alive too long, that it can preserve life when life ought not to be preserved and when efforts to save the body can do more harm than good?"

Other essays consider the issue of allocation of scarce medical resources. Is it ethical to spend the multi-million dollars of high technology medicine to save a Baby Fae in a world where that amount could save thousands from starvation? Does a Third World country in which 50,000 children die each year of diseases which could be prevented by vaccination need a Hospital Humana de Pedregal to concentrate medical services in the hands of the oligarchy and export the profits to the West? Allocation of scarce organ transplants is discussed by two of the authors. In a society where the people who could benefit from a transplant exceed by severalfold the available organs, how does one decide whom should receive the transplant? To what extent should society establish a "green screen" [i.e. If you don't have money, you don't receive the procedure.], consider social utility and individual merit? Yet, all of these criteria are used to exclude persons from consideration.

The meaning of life and personhood is also examined. Walters asks if current Department of Health and Human Services guidelines require a ". . . prolongation of suffering that itself borders on child abuse." Larson also wonders what it means to be a person in a society which has devalued Blacks, Jews, children, women and fetuses. Then he asks if it is possible that there are persons who are not human as well as humans who are not persons.

One who is expecting clear and definitive answers to ethical issues will not be satisfied with this book. I have more questions than I had before I read the book. But, I think that I better understand some of the issues. This seems to be the purpose of the Ethics Center: identify basic issues, promote their discussion. Those interested in biomedical ethics will welcome this book. I look forward to future volumes.

Chaplain (MAJ) Temple G. Matthews III
U.S. Army

Truly Ourselves, Truly the Spirit's

Laurence W. Wood

Grand Rapids: Francis Asbury Press, 1989, Soft cover, 238 pages.

Dr. Laurence Wood, an ordained United Methodist Elder, is the Frank Paul Morris Professor of Christian Doctrine at Asbury Theological Seminary. He serves as the editor of *The Asbury Theological Seminary Journal.*

Truly Ourselves, Truly the Spirit's examines the nature of living a Spirit-filled life and developing a friendship or intimate relationship with God. Dr. Wood uses biblical, scholarly and personal approaches to investigate the subject. He defines spirituality in this way, "Some have an experience with God which is truly 'spiritual' and 'pentecostal' in the New Testament sense; they enjoy a genuinely intimate relationship with God through the Spirit of Christ."

The author uses a relational approach to theology to present a theology of the Holy Spirit. God waits for us, offers us friendship and has given the Spirit to form us into the image of Christ. A Spirit-filled life involves counting the cost, making an effort to live in relationship with God, and finding true peace and freedom. Each of the twelve chapters deals with a different aspect of the Spirit. The approach does not direct the reader down a particular path or discipline, but encourages one to allow the Spirit to fill them. The author frequently cites the works of Wesley and other early Methodists, while overlooking other writers and traditions of Christian spirituality.

This book provides a very good introduction to spirituality viewed in a relational manner. *Truly Ourselves, Truly the Spirit's* does not exclude any tradition, but would gain a wider appeal with a diversity of sources. Dr. Wood's style moves the reader through the reflections, while encouraging an examination of the Spirit's role in developing a Spirit-filled life. The inspirational nature and biblical basis provide a strong foundation for further investigation. I would commend the book for those trying to understand the Spirit-filled life, especially from a Wesleyan tradition.

Chaplain (CPT) Robert J. McGeeney, Jr.
U.S. Army

Living With Your Dreams (Let God Restore Your Shattered Dreams)

David Seamands

Victor Books, 1990, Hard cover, 168 pages, $14.95.

David Seamands is a United Methodist minister. He served as a missionary in India for about 16 years. He has pastored the United Methodist Church in Willmore, Kentucky. He is now Dean of Chapel and Professor of Pastoral Ministries at Asbury Theological Seminary. He is the author of several books, including *Healing For Damaged Emotions, Putting Away Childish Things* and *Healing Grace.*

David Seamands uses the life of Joseph as a vehicle to show how in the face of hardship, disappointment, discouragement, a person can still have dreams come true. He used ten chapters to discuss dreams, as they apply to daily living. Dr. Seamands also uses events from his own life to show how God used disappointment and tragedy to change and enhance his own ministry and personal dreams.

I have read several of this author's previous books. I have found each of them helpful in my counselling ministry. I have loaned his books out. I feel this book will be helpful to some of the people I serve as they deal with broken dreams, especially those that have been passed over. The two chapters that deal with forgiveness makes this book worth the purchase price.

Chaplain (CPT) Thomas C. Condry
U.S. Army

Love is a Decision

Gary Smalley with John Trent

Word Publishing, 1989, Hard cover, 215 pages, $14.95.

Gary Smalley, president of Today's Family in Phoenix, has a bachelor's degree in psychology, and a master of divinity from Bethel Seminary in St. Paul, Minnesota. He and his wife, Norma, have three children: Kari, Greg and Michael. Other books he has written are: *If Only He Knew, For Better or for Best, The Key to Your Child's Heart, The Joy of Committed Love, Joy That Lasts,* and *The Language of Love.*

Once again Gary Smalley has written a book that is extremely helpful. Just as in his other books, the concept of the marriage and family relationship reflecting the Christ and His Church relationship (Ephesians 5:20-6:4) comes through strong. This concept is the basis for the theme of his book, which is also its title, *Love is a Decision.*

Throughout the book he refers to scripture as his basis of thought. I personally appreciate that approach. It is the overwhelming strength of the book for me. Not only does he use scripture as his basis of thought, but he also gives descriptive stories of how its application has worked out in his marriage. Most of the stories are humorous and easily adapted to use in marital counseling.

Gary Smalley has written fourteen chapters in this book. Each chapter is quite easy to read and kept my interest quite easily. The material in the book is based on the "Love is a Decision" seminar he sponsors with John Trent. My favorite chapters were "The Incredible Worth of a Woman" and "Energizing Your Mate in Sixty Seconds."

In "The Incredible Worth of a Woman," Smalley discusses the complementing value of a wife. Here he tells the very distinct differences of a woman and a man and how those differences help to complete a man (Genesis 2:18b). I really liked reading about mom's "radar system" which allows her the ability to keep track of the kids without seeing them. In contrast, "Many

a wife knows that if she leaves the house for an hour with her husband 'in charge' of the kids, she's likely to come back and not see them anywhere in sight." A true statement for my house.

In "Energizing Your Mate in Sixty Seconds" he speaks of being tender. Gentleness is the strength of a relationship in those crisis moments. "Remaining tender during a trial is one of the most powerful ways to build an intimate relationship (James 1:19, 20)." To be gentle is a decision during trials, not necessarily what we feel like being. Tenderness is only a part of what energizes your mate.

Love is a Decision is a useful tool in marital counseling or as a basis for a marriage enrichment retreat. I recommend the book for personal reading as well as professional use.

Chaplain (CPT) David A. Pollok, Jr.
U.S. Army

What Every Christian Should Know

Jo H. Lewis & Gordon A. Palmer

Victor Books, 1989, Hard cover, 188 pages.

Jo H. Lewis is associate professor of English at Friends Bible College, Haviland, Kansas. Gordon A. Palmer is chairman of the Department of Education and assistant professor of education and music at Trinity College, Deerfield, Illinois.

What Every Christian Should Know contains a foreword, eight chapters, and two appendixes. The appendixes contain a list of words and a suggested reading list Christians should know. The chapters ask these questions:

1. Do Christians Know What They Need to Know?
2. Is Christian Knowledge Important?
3. How Can We Find What Is Essential?
4. What Do You Know? Test Yourself
5. What Do Literate Christians Know?
6. Has the Torch Been Passed or Dropped?
7. What Must We Do?
8. What Will Happen?

This book offers reasons and solutions for the decline in Christian knowledge. Extensive original research shows that young adults know less than older adults. The authors view the public school system as the prime culprit. The Bible and classics once present are absent.

The problem goes deeper. Students lack drive and motivation to study the Bible. The reasons listed include "insecurity, ultraindividualism, apathy, rock music, passivism, and a failure to read."

The authors suggest lifestyle changes. Changes needed include "reading, studying, singing, teaching, praying, and gathering together." The church

is central to renewal. We must "return to the old ways (Jeremiah 6:16)." The authors strongly emphasize "Bible reading, music, church traditions, and preaching." To facilitate growth, the authors include a self-test of Christian knowledge, a list of terms, and an extensive bibliography.

The research sample is the main weakness of the book. Subscribers to *Christianity Today* and *Campus Life* responded to a survey regarding Christian knowledge. The authors surveyed a literate Christian audience, weakening the results. A broader sample would strengthen the authors' conclusions. Working with congregations for sixteen years, I agree that literate Christians are in the minority.

The authors believe knowledge brings renewal. Knowledge is important, but alone does not bring renewal. Renewal comes when the church prays and repents.

Every chaplain should read this book. *What Every Christian Should Know* provides tools for church renewal. This back-to-basics book calls chaplains to lead in educating the chapel congregation. Our survival requires congregations educated in the basics of the Christian faith.

Chaplain (CPT-P) Alan C. Hendrickso
U.S. Army

How to Really Love Your Child

D. Ross Campbell, M.D.

New American Library, Pearson, Inc. 1633 Broadway, New York, NY 10019, 1982.

Soft cover, 132 pages, $4.95 ISBN 0-451-16186-6

D. Ross Campbell, M.D. is a psychiatrist with Area Psychological Clinic, Chattanooga, Tenn., where he specializes in working with young children. He is the father of two sons and two daughters and brings insight from both home and clinical experience. Among his best known books are KIDS WHO FOLLOW, KIDS WHO DON'T and HOW TO REALLY LOVE YOUR TEENAGER.

In the preface, Dr. Campbell states "This is a book written primarily for parents of children younger than adolescents. Its intention is to give mothers and fathers an understandable and usable way of approaching their wonderful, yet awesome, task of raising each child."

I personally feel it is the best, easiest-to-read book I have read in years with value to parents and grandparents of all ages as well as those working with children in school or chapel settings.

Dr. Campbell first identifies the prerequisites for good child rearing, starting from the home and marital relationship. Then he describes in detail "How to Love Your Child" with emphasis on eye contact, physical contact and focused attention. Love is seen in terms of APPROPRIATE LOVE which he defines as "that love which, when conveyed to a child, will provide

healthy nurturing and foster a child's emotional growth and self-reliance." He then defines INAPPROPRIATE LOVE as "affection which, when conveyed to a child, hinders a child's emotional growth by failing to meet a child's emotional needs, and which fosters an increasingly dependent relationship upon a parent and hampers self-reliance."

The three chapters on discipline are the high point of this excellent book. He declares that "making a child feel loved is the first and most important part of good discipline." Discipline is defined as "training a child in mind and character to enable him to become a self-controlled, constructive member of society." He notes that less punishment is required for the loved child who has been disciplined. He notes that most behavior in a child is determined by how much the child feels loved; that the constant "testing" of our love by behavior is asking "Do you love me?"

Dr. Campbell views discipline as Requests, Commands, Rewards and Punishment. Requests are the most positive way of achieving good behavior as they instill a sense of personal responsibility. Commands are more forceful than requests; they are direct instruction and involve adult help in accomplishing the task including physically moving, or removing, the child from the temptation at hand. Rewards and Punishment are forms of behavior modification reserved for occasions when requests and commands fail. Rewards and Punishment are less desirable approaches since they frustrate the need a child has for unconditional love.

The chapter entitled "Children with Special Problems" is especially helpful in handling the emotional and behavioral problems that often come from long-standing medical problems. The closing chapter entitled "Helping Your Child Spiritually" discusses the incorporation and acceptance of parental values.

I especially appreciated Dr. Campbell's approach to firm discipline leading to self-discipline founded on being truly loved and valued by others. This book is easy- to-read and firmly based upon healthy love and self-discipline for our children. It would be an excellent, inexpensive book to give to families and school/chapel workers.

Chaplain (COL) Wayne R. Ward
USA, Retired

Saint of the Day

Leonard Foley, OFM

St. Anthony Messenger Press, 1990, Hard cover, 355 pages, $19.95.

Recently many of our nation's "heroes" have been returning from Desert Storm. Our people have rediscovered how much they enjoy having someone to look up to again. This book takes the heroes of Christian history and introduces us to them in a very useful way.

Father Foley has collected the lives and stories of saints from the time of the apostles to some who have lived this century. He presents a (1 or 2

page) description of their extraordinary love for God—lived out in ordinary lives with which we can identify. He clearly separates fact from legend, but deftly lets both aspects of these accounts inspire us. The saints become just as real as if they were living next door.

The arrangement Fr. Foley uses in this book is the sequence order of the official saints feasts in the Roman Catholic church calendar. Everyone knows St. Patrick day on March 17, but Fr. Foley introduces us to many others from every century and continent. He also includes an easy to use alphabetical index for finding these saints' dates.

Although not all who admire the saints will feel obliged to "program" them through the year the way the Catholic Church does, they will find this book able to speak in a contemporary way, with all the needed details, of the heroes whose faith and dedication we can share. It is written with pluralistic sensitivity, is useful for any denomination, and delightful reading for all.

Chaplain (CPT) Patrick J. Dolan
U.S. Army

The American Dream Renewed: The Making of A World People

Edward L. Ericson

The Continuum Publishing Company, 1991, Hard cover, 173 pages, $18.95.

Edward L. Ericson served as leader of the Washington Ethical Society during the civil rights movement of the 1960s. Active in civil liberties, human rights, peace, and ecological issues, Mr. Ericson has authored *American Freedom and the Radical Right, The Free Mind through the Ages, The Humanist Way*, and edited *Emerson on Transcendentalism.*

America owes its economic growth, intellectual creativity, a rebirth of its civic freedoms, and a resupply of spiritual strength to continuous and diverse immigrant peoples. The author's purpose is to explain why his belief is held and why this belief has the potential to encompass the world.

The "American dream," to the immigrant, includes at least "the chance to be treated as a man or woman ought to be treated, and the opportunity to make oneself whatever that man or woman is capable of becoming" (page 10). The United States of America is a great democracy that is still evolving, beyond its geographical boundaries into the vision of a "world nation."

To reach this conclusion the author traces the history of American immigration. With religious dissent as a motivator for many early immigrants, Ericson discusses the development of the American Constitution as guarantor of human freedom, especially in regard to church state relations.

A major blight on the American dream was American slavery. Lincoln's presidency was a brilliant turning point that enabled the American dream to remain viable. Social and economic development since Lincoln has brought America to a place of world leadership. "The immigrant has been a primary carrier of the energies of idealism, innovation, and renewal" (page

167). The "American model" must continue to assure the renewal of the American Dream in a shrinking world that seeks to learn the lessons of pluralism and intercultural living. The implications of this "Dream" are evident in a series of world events that include the razing of the Berlin Wall.

Many of Ericson's thoughts have a ring of truth and the reader may be ready to take the whole bait. The simplistic idealism that implies the world's problems may be solved by a single vision leaves this reader a bit perplexed. Aside from this concern, I like the book and believe it points in a positive direction for framing many complex issues of today.

Commander J. H. Martin
Chaplain Corps, US Navy

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Coming in Future Issues of the Military Chaplains' Review . . .

Operation Desert Shield/Storm — Summer 91

We take a look at the ministry of allied chaplains in the rugged and gritty arena of Saudi Arabia, Iraq, and Kuwait, and also the faithful efforts of chaplains who remained behind to minister in CONUS and USAREUR.

Evangelism and Discipleship in the Military — Fall 1991

How do we disciple new converts to the faith, and strengthen older hearts and hands in the face of challenges to their faith? How can we evangelize in a pluralistic religious community without offending others? We explore these issues in this issue, and would be delighted to have your ideas. What are you doing that works?

Twentieth Anniversary Issue — Winter 1992

The Military Chaplains' Review is 20 years old! We celebrate its birthday in this issue.

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